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EDITOR'S NOTE

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65-688-CFX Title: Metropolitan Life Insurance Company, Petitioner  
Status: GRANTED V.  
Arthur Taylor  
cketed: Court: United States Court of Appeals  
October 22, 1985 for the Sixth Circuit  
Re: Counsel for petitioner: Toppeta, William J.  
65-688 Counsel for respondent: Scheer, Peter E.

try	Date	Note	Proceedings and Orders
1	Oct 22 1985	G	Petition for writ of certiorari filed.
2	Dec 4 1985		DISTRIBUTED. January 10, 1986
3	Dec 19 1985	P	Response requested. (Due January 18, 1986 - NONE RECEIVED)
4	Jan 17 1986		Brief of respondent Arthur Taylor in opposition filed. VIDE.
5	Jan 22 1986		DISTRIBUTED. February 21, 1986
6	Jan 22 1986		DISTRIBUTED. February 21, 1986
7	Feb 24 1986		Petition GRANTED. The case is consolidated with 65-688, and a total of one hour is allotted for oral argument. *****
9	Mar 27 1986		Order extending time to file brief of petitioner on the merits until May 3, 1986.
10	Apr 26 1986		Record filed.
11	Apr 26 1986		Certified C. A. proceedings and joint appendix received.
12	Apr 28 1986		Record filed.
13	May 2 1986		Joint appendix filed. VIDE.
14	May 2 1986		Brief amicus curiae of EKISA Industry Committee filed. VIDE.
15	May 2 1986		Brief of petitioner Metro. Life Ins. Co. filed. VIDE.
16	May 9 1986		Order extending time to file brief of respondent on the merits until July 1, 1986.
17	Jul 1 1986		Brief of respondent Arthur Taylor filed. VIDE.
18	Jul 25 1986		CIRCULATED.
19	Nov 14 1986		SET FOR ARGUMENT. Wednesday, January 21, 1987. This case is consolidated with No. 85-688. (1st case) (1 hour)
1	Jan 9 1987		Reply brief of petitioners GPC, et al. filed. VIDE.
2	Jan 9 1987		Logging received. (10 copies).

**PETITION  
FOR WRIT OF  
CERTIORARI**

85-686

No. \_\_\_\_\_

Supreme Court, U.S.

FILED

OCT 22 1985

JOSEPH F. SPANIOL, JR.  
CLERK

IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1985

METROPOLITAN LIFE INSURANCE COMPANY,

*Petitioner,*

—v.—

ARTHUR TAYLOR,

*Respondent.*

**PETITION FOR A WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT**

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**QUESTION PRESENTED**

Did the Court of Appeals for the Sixth Circuit err in holding that an action alleging breach of contract and seeking disability benefits provided under an ERISA employee welfare benefit plan was not properly removed from state court to a United States District Court?<sup>1</sup>

---

<sup>1</sup> General Motors Corporation was named as a defendant below but is not a party to this Petition.

In accordance with Supreme Court Rule 28.1, Metropolitan Life Insurance Company states that, with the exception of wholly-owned subsidiaries, it owns a controlling interest of more than 50% in only one entity, Dawn Water Company.

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1985

No. \_\_\_\_

METROPOLITAN LIFE INSURANCE COMPANY,

*Petitioner,*

—v.—

ARTHUR TAYLOR,

*Respondent.*

**PETITION FOR A WRIT OF CERTIORARI  
 TO THE UNITED STATES COURT OF APPEALS  
 FOR THE SIXTH CIRCUIT**

**OPINIONS BELOW**

The opinion of the District Court is reported as *Taylor v. General Motors Corporation and Metropolitan Life Insurance Company*, 588 F.Supp. 562 (E.D. Mich. 1984), and is reprinted in Appendix A. The May 4, 1981 order of the District Court is reprinted in Appendix B. The opinion of the Court of Appeals for the Sixth Circuit is published at 763 F.2d 216 and is reprinted in Appendix C. The order of denial of rehearing and rehearing *en banc* is reprinted in Appendix D.

## JURISDICTION

The opinion of the Court of Appeals was filed on June 7, 1985. The order denying rehearing and rehearing *en banc* was entered on July 25, 1985. This Court has jurisdiction pursuant to Section 1254(1) of Title 28 of the United States Code.

## STATUTORY PROVISIONS INVOKED

29 U.S.C. § 1001(b) states that it is the policy of ERISA "to protect interstate commerce . . . ."

29 U.S.C. § 1132(a)(1)(B) provides:

(a) a civil action may be brought—

(1) by a participant or beneficiary—

. . . .  
(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . .

29 U.S.C. § 1132(e)(1) states, in pertinent part, as follows:

(e)(1) State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

28 U.S.C. § 1337(a) states that the "district courts shall have original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce . . . ."

28 U.S.C. § 1441(a) provides, in pertinent part, that "any civil action brought in a state court of which the district courts of the United States have original jurisdiction, may be

removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending."

## STATEMENT OF THE CASE

The issue decided by the Court of Appeals was that an action alleging breach of contract and seeking disability benefits provided under an ERISA employee welfare benefit plan was not properly removed to the United States District Court.<sup>2</sup>

## STATEMENT OF FACTS

Petitioner Metropolitan Life Insurance Company (Metropolitan) adopts that portion of the Petition for a Writ of Certiorari to be filed on October 23, 1985 by General Motors Corporation (General Motors) which sets forth the facts of the case.

## THE DECISION OF THE COURT OF APPEALS

After reviewing the authorities relied upon by Metropolitan, General Motors and plaintiff, the Sixth Circuit concluded that "[a]lthough the issue is certainly not free from doubt, we are persuaded that plaintiff has confined his claim against Metropolitan to one based on state law, and the well-pleaded complaint rule precludes removal." 763 F.2d at 219, App. at 17a-18a.

The court admonished that it was expressing "no opinion concerning whether Congress intended ERISA to preempt the type of claim brought by plaintiff in this case." 763 F.2d at 220, App. at 18a. The Court believed that its opinion in *Taylor* was not inconsistent with its previous determination on a

<sup>2</sup> Federal jurisdiction *vel non* is the sole issue in this case. Therefore, this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, \_\_\_ U.S. \_\_\_, 105 S. Ct. 2380 (1985), is not relevant.

substantive ERISA preemption question in *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir. 1985):

In *Authier* the court was concerned not with whether it had jurisdiction, but with the substance of the asserted preemption defense. In contrast, we here are concerned not with the merit of the preemption defense, but rather with whether jurisdiction exists in the first instance. The questions are separate and distinct. 763 F.2d at 220 n.1, App. at 18a n.1.

In the Court's opinion, it is "not 'clearly established' that actions for benefits allegedly due under a group insurance policy 'necessarily' arise under federal law simply because the insurance policy is part of an overall benefit plan established pursuant to ERISA." 763 F.2d at 219, App. at 18a. In support of its position, the Court cited the Decision of the Fifth Circuit Court of Appeals in *Powers v. South Central United Foods & Commercial Workers Unions and Employees Health and Welfare Trust*, 719 F.2d 760 (5th Cir. 1983), as well as a number of federal district court opinions.

The Sixth Circuit recognized, however, that "a definite split of authority exists" as to whether a complaint to recover benefits due under a group insurance contract necessarily arises under federal law, where ERISA plan benefits are provided through an insurance contract. 763 F.2d at 219, App. at 16a. The Court noted, therefore, that its opinion was squarely in conflict with the holding of the Tenth Circuit Court of Appeals in *Roe v. General American Life Insurance Co.*, 712 F.2d 450 (10th Cir. 1983), as well as with several federal district court decisions.

In the opinion of the Court, its holding was consistent with the Supreme Court's decision in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983). *Franchise Tax Board* was cited for the proposition that removal jurisdiction is dependent upon the four corners of the complaint, i.e., the complaint must establish that the case arises under federal law, and, that defenses based upon federal preemption of state law do not confer federal jurisdiction.

Finally, the Sixth Circuit recognized "that as a general rule courts permit removal to federal court, notwithstanding the well-pleaded complaint doctrine, where an employee in a labor case attempts to assert a common law cause of action against his employer" because "regardless of the wording of the complaint it is clear that the claim must necessarily arise under federal law." 763 F.2d at 220, App. at 19a. Application of this principle by analogy was rejected by the Court because "like the Fifth Circuit . . . [the Sixth Circuit] find[s] cases implicating ERISA to differ from those involving the federal labor laws generally." 763 F.2d at 220, App. at 19a.

On the basis of the above analysis, the Court reversed the judgment of the district court and ordered the case remanded with instructions to transfer the case to state court.

### LEGAL ARGUMENT: THE TAYLOR CASE MEETS THIS COURT'S CRITERIA FOR A WRIT OF CERTIORARI

#### I. A Split of Authority Exists Between Federal Circuit Courts.

Supreme Court Rule 17.1(a) provides that a consideration favoring certiorari is that a split of authority exists between federal circuit courts. *See also, Bingler v. Johnson*, 394 U.S. 741, 747-748 (1969). Both the Sixth and Tenth Circuits have recognized that there is a conflict on the issue presented in this case—whether an action for benefits under an ERISA plan is removable to federal court when the complaint is framed as a breach of contract action under state law. While the Sixth Circuit opinion in *Taylor* is consistent with the Fifth Circuit holding in *Powers v. South Central United Food & Commercial Workers Unions and Employees Health & Welfare Trust*, 719 F.2d 760 (5th Cir. 1983), both opinions directly conflict with the Tenth Circuit decision in *Roe v. General American Life Insurance Co.*, 712 F.2d 450 (10th Cir. 1983), and with several federal district court decisions. 763 F.2d at 218-219, App. at 15a-17a.

In *Roe*, a plan participant filed suit in state court seeking to recover benefits provided to participants under an ERISA employee benefit plan through a policy of insurance. The complaint was based solely on a state law breach of contract theory. The defendant removed the case to federal court and the plaintiff unsuccessfully moved to remand the action to state court. The Tenth Circuit held that an "insurance program of the sort here involved does come within the ambit of ERISA, and the case was properly removed." *Roe*, 712 F.2d at 452.

In view of this split of authority and the resulting inconsistencies which will follow, Metropolitan respectfully submits that this Court should review this matter and render a decision to be followed in all Circuits.

The *Taylor* case presents the Supreme Court with a rare opportunity to review the issue of removal jurisdiction. The question is not likely to present itself again to this Court in the near future, as most cases addressing the issue would not be appealable. Under 28 U.S.C. § 1447, a decision by a district court to remand a case to state court is not reviewable on appeal. *See Volvo of America Corp. v. Schwarzer*, 429 U.S. 1331 (1976). District courts, following the precedents established in the Fifth and Sixth Circuits, will remand these cases to state courts and these decisions will not be subject to review. This Court, however, has the power to review *Taylor*, a Court of Appeals decision. *See Aetna Casualty & Surety Co. v. Flowers*, 330 U.S. 464, 467 (1947).

## II. An Important But Unresolved Question of Federal Law Is Presented in this Case.

Another consideration militating in favor of granting certiorari is set forth in Supreme Court Rule 17.1(c). That section provides that granting a petition is proper "[w]hen a federal court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court . . . ." The important question of federal law is whether a plaintiff can defeat the original jurisdiction of the

federal courts over ERISA cases simply through artful pleading. The Fifth and Sixth Circuits have resolved this question in the affirmative, whereas the Tenth Circuit has rejected that view.

The opinion of the Sixth Circuit relied on this Court's decision in *Franchise Tax Board*, 463 U.S. 1. There, however, the Court expressly did not resolve the question whether actions such as Taylor's are properly removed to federal court. *Franchise Tax Board* held only that a lawsuit by a state tax authority to collect certain funds from an employee benefit plan was not properly removable to federal court. The opinion noted that (a) ERISA "neither creates nor expressly denies any cause of action in favor of state governments"; (b) "the State's right to enforce its tax levies is not of central concern to the federal statute . . ." and (c) ERISA "does not provide an alternative cause of action in favor of the State to enforce its rights . . . ." 463 U.S. at 24. In contrast, however, this Court recognized that "the express grant of federal jurisdiction in ERISA is limited to suits brought by certain parties [participants, beneficiaries, plan fiduciaries and the Secretary of Labor] as to whom Congress presumably determined that a right to enter federal court was necessary to further the statute's purposes." 463 U.S. at 21.

Applying the *Franchise Tax Board* rationale to the case at bar, it appears that this Court would find that Taylor's suit was properly removed to federal court notwithstanding the fact that state law was pleaded in the Complaint. It is beyond dispute that ERISA creates an express cause of action in favor of Taylor, a plan participant, for the recovery of benefits provided under the General Motors Plan. Moreover, protection of a participant's right to benefits is of central concern to ERISA.

Review of *Taylor* will allow the Court to address this important question of federal jurisdiction not resolved in *Franchise Tax Board*.

**III. The Decision of the Court of Appeals Is Clearly Erroneous Because Removal of the Action Was Proper Pursuant to 28 U.S.C. § 1441(a).**

The plain language of the general removal statute, of ERISA, and of related statutes establishes that the Sixth Circuit erroneously held that the federal district court did not have removal jurisdiction. A civil action like Taylor's falls squarely within the class of actions that can be removed to federal court.

The removal statute, 28 U.S.C. § 1441(a), provides that any civil action of which "the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending."

The question of whether an action can be removed to federal court is a threshold question. As the Sixth Circuit recognized the question of removal jurisdiction is separate and distinct from any determination on the merits of the case. The issue is simple: does the federal court have original jurisdiction over the action which is to be removed from state court?

**A. The District Court Has Jurisdiction Over Taylor's Action Pursuant to 29 U.S.C. § 1132(e)(1).**

An underlying principle of the Federal Rules of Civil Procedure is that pleadings are merely designed to give the defendant notice of the plaintiff's claim and not to resolve substantial issues in lawsuits. See *Conley v. Gibson*, 355 U.S. 41, 48 (1957). It is evident from Taylor's complaint that he sought disability payments available to employees of General Motors as benefits of their employment. See Complaint, reprinted in Appendix E, at 25a. General Motors provided those benefits through an insurance policy issued by Metropolitan. 763 F.2d at 217-218, App. at 14a. If Taylor had not been an employee of General Motors and a participant in the General Motors Plan,

he would have had no claim to any of the disability benefits provided under that Plan through the Metropolitan contract.

Taylor's lawsuit is necessarily, therefore, a civil action "(1) by a participant or beneficiary— . . . (B) to recover benefits due to him under the terms of his plan . . . ." 29 U.S.C. § 1132(a)(1)(B). Pursuant to 29 U.S.C. § 1132(e)(1), federal district courts and state courts have concurrent original jurisdiction of actions for plan benefits under 29 U.S.C. § 1132(a)(1)(B). To find otherwise would cause form to triumph over substance. Complaints for benefits available under ERISA plans would become an exception to the Federal Rules and masterpieces of "an art in writing nice pleadings." 2A J. MOORE, MOORE'S FEDERAL PRACTICE ¶ 8.02 at 8-9 (2d Ed. 1985).

In addition to the opinion of the Tenth Circuit in *Roe v. General American Life Insurance Co.*, 712 F.2d 450 (10th Cir. 1983), several district courts have held that, even if the plaintiff styles his complaint as a state law claim, a claim for benefits provided by an ERISA plan is removable to federal district court. *Tolson v. Retirement Committee of the Briggs and Stratton Retirement Plan*, 566 F.Supp. 1503 (E.D. Wis. 1983); *McConnell v. Marine Engineers Beneficial Association*, 526 F.Supp. 770 (N.D. Cal. 1980); *Testa v. CIBA-GEIGY Corp.*, 84 Civ. 9170 (S.D.N.Y. September 3, 1985) (See Appendix F).

**B. Since ERISA Is a Law Which Is Intended to Regulate Interstate Commerce, 28 U.S.C. § 1337 Authorizes Removal to Federal Court of Actions for ERISA Plan Benefits.**

Congress has declared that a fundamental policy of ERISA is "to foster and facilitate interstate commerce" and to protect both "interstate commerce and the interests of participants in employee benefits plans . . . ." 29 U.S.C. §§ 1001a(c)(1) and 1001(b). Congress has also mandated that "the district courts shall have original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce . . . ." 28 U.S.C. § 1337(a). Lawsuits by ERISA plan

participants are within original federal jurisdiction and are therefore removable to federal court pursuant to 28 U.S.C. § 1441(a).

Decisional law supports the proposition that 28 U.S.C. §§ 1337(a) and 1441(a) establish that federal courts have original and removal jurisdiction over an action by a plan participant for ERISA benefits "irrespective of whether the plaintiff intended to allege a federal or state claim . . . ." *Leonardis v. Local 282 Pension Trust Fund*, 391 F.Supp. 554, 557 (E.D. N.Y. 1975). Case law involving other federal statutes that regulate interstate commerce has established that actions involving those laws are also removable to federal court. See *Olguin v. Inspiration Consolidated Copper Co.*, 740 F.2d 1468, 1472 (9th Cir. 1984) (29 U.S.C. § 185, Labor-Management Relations Act of 1947 (LMRA)); *Eitmann v. New Orleans Public Service, Inc.*, 730 F.2d 359, *reh'g denied*, 739 F.2d 437 (5th Cir. 1984), *cert. denied*, \_\_\_ U.S. \_\_\_, 105 S.Ct. 433 (1984) (LMRA); and *First Federal Savings & Loan Association of Jackson County v. First Federal Savings & Loan Association of Huntsville*, 446 F.Supp. 210, 212 (N.D. Ala. 1978) (12 U.S.C. § 1461, Home Owner's Loan Act of 1933).

**C. By Analogy, Decisional Law Under the Labor-Management Relations Act of 1947 Supports Removal of Actions by ERISA Plan Participants for Benefits.**

Taylor's cause of action comes directly within the scope of 29 U.S.C. § 1132(a)(1)(B) as an action by a participant for benefits provided under an ERISA employee benefit plan. The House Conference Committee report discussing ERISA stated:

All such actions in Federal or State Courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947 [29 U.S.C. § 185].

H.REP. NO. 93-1280, 93rd Cong., 2nd Sess., *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 5107 (emphasis added). When Congress made that statement, this Court had already

specifically ruled that a lawsuit on a subject coming within the scope of the LMRA was removable to federal court, even if the complaint did not itself rely on federal law. *Avco Corp. v. Aero Lodge 735, International Association of Machinists & Aerospace Workers*, 376 F.2d 337 (6th Cir. 1967), *aff'd*, 390 U.S. 557 (1968).

In *Avco*, the plaintiff filed suit in a Tennessee state court to enjoin a labor union and its members from striking. Plaintiff (a) characterized the complaint as one for breach of contract arising under state law and (b) argued that a "no strike" clause in the collective bargaining agreement required all labor disputes to be settled by arbitration. 376 F.2d at 340.

This Court held that the lawsuit was properly removable to federal court, noting that "[a]n action arising under § 301 is controlled by federal substantive law even though it is brought in a state court." 390 U.S. at 560 (footnote omitted). The Court held that the lawsuit arose under "the laws of the United States." Thus, the action was "within the 'original jurisdiction' of the District Court within the meaning of the removal statute," notwithstanding the manner in which the complaint was framed. 390 U.S. at 560. Other cases following *Avco* have held that removal is appropriate in cases involving labor-management issues, despite the fact that, on its face, the complaint in each case did not rely on federal law. See *Olguin*, 740 F.2d 1468 and *Eitmann*, 730 F.2d 359.

In *Franchise Tax Board*, 463 U.S. 1, the Supreme Court compared actions brought under 29 U.S.C. § 1132(a) by analogy to those filed under section 301 of the LMRA (29 U.S.C. § 185). The opinion stated that:

[i]t may be that, as with § 301 as interpreted in *Avco*, any state action coming within the scope of § 502(a) of ERISA [29 U.S.C. § 1132(a)] would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law. 463 U.S. at 24.

Although Taylor characterized his complaint as a breach of contract action under state law, the action actually comes within the scope of 29 U.S.C. § 1132(a)(1)(B). This is evident even within the four corners of the complaint as plaintiff alleged that he was seeking benefits which General Motors agreed to provide under its "employee benefits program." 763 F.2d at 218. App. at 15a. The benefits described in the Complaint were made available to participants of the General Motors plan through a group insurance policy issued by Metropolitan. The level of benefits and eligibility requirements were dictated by the terms of the General Motors Plan itself. See Page 1 of Metropolitan's Reply Memorandum in District Court on Summary Judgment Motion, reprinted in Appendix G at 37a.

### CONCLUSION

For the above reasons, Metropolitan requests that this Court grant its petition for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit.<sup>3</sup>

Respectfully submitted,

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Dated: October 22, 1985

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<sup>3</sup> It is respectfully submitted that this Court may wish to reverse summarily the clearly erroneous decision of the Sixth Circuit.

## **APPENDICES**

**APPENDIX A**

**UNITED STATES DISTRICT COURT  
E.D. MICHIGAN, S.D.**

May 17, 1984

No. 81-40304

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ARTHUR TAYLOR,

*Plaintiff,*

—v.—

GENERAL MOTORS CORPORATION, a foreign corporation and  
Metropolitan Life Insurance Company, a foreign corpora-  
tion, jointly and severally,

*Defendants.*

---

Discharged employee brought action against employer and employer's disability insurer, alleging failure to promote and retaliatory discharge against employer, and breach of insurance contract against disability insurer. The District Court, Newblatt, J., held that: (1) employee was not entitled to disability benefits for a psychological condition; (2) employee was not entitled to disability benefits for back injury; (3) even if employer's "open door" policy described in employee handbook created impression that employment would be terminated only for just cause, where employee was fired after ignoring a letter to return to work after he had been found able to work, employee could not recover from employer on claim of breach of open door policy; (4) employee did not make out retaliatory

discharge case; and (5) employee's failure-to-promote claim was time barred by three-year statute of limitations.

Motions granted.

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JAMES A. BRESCOLL, Mount Clemens, Mich., *for plaintiff*.

DAVID M. DAVIS, Detroit, Mich., GILBERT Y. RUBENSTEIN, Flint, Mich., *for defendants*.

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#### MEMORANDUM OPINION AND ORDER

NEWBLATT, *District Judge*.

This matter comes before the Court on defendant Metropolitan Life Insurance Company's (Metropolitan) renewed motion for a separate trial, Metropolitan's renewed motion for partial summary judgment on the issue of disability benefits for a back condition raised in Count II, Metropolitan's renewed motion for partial summary judgment on the issue of disability benefits for a psychological condition raised in Count II, and defendant General Motors Corporation's (GM) motion for summary judgment on Counts I and III. Because of the disposition of Metropolitan's two motions for partial summary judgment, the Court need not address Metropolitan's motion for a separate trial.

Plaintiff filed this cause of action in Wayne County Circuit Court on March 13, 1981. On March 24, 1981, GM, with the concurrence of Metropolitan, properly removed the case to this court, citing the Employee Retirement Insurance [sic] Security Act, 29 U.S.C. § 1132(a), as the basis of jurisdiction. This Court permitted plaintiff to amend his complaint on October 10, 1983, and on October 24, 1983, plaintiff filed his first amended complaint, alleging in Count I that GM failed to promote plaintiff and finally terminated him on November 5,

1980 in retaliation for his filing workers' compensation claims against GM in 1964, and for exercising his rights under the "Open Door" policy, asserting in Count II that Metropolitan had breached its insurance contract with plaintiff by refusing to award him disability benefits for a back injury and psychological problems, and claiming in Count III that plaintiff had been discharged in breach of his employment contract.

#### FACTS

Plaintiff commenced salaried employment with GM as a 5th level Engineering Analyst in the Fisher Body Division on June 25, 1959. He was promoted to 6th level Quality Control Analyst on September 1, 1959, and on March 1, 1960, plaintiff was promoted to 7th level Senior Engineer and transferred to the Chevrolet Central Office.

On March 31, 1960, plaintiff entered into an employment contract with GM, which provided in pertinent part:

\* \* \*

2. The Employee acknowledges that his employment under this agreement is from month to month only on a calendar month basis.

6. The Employer and the Employee acknowledge that there are no other arrangements, agreements, or understandings, verbal or in writing, regarding same and that any modification or amendment hereof, other than a cancellation and replacement hereof by another written form of agreement, must be endorsed hereon in writing and initialed by both the Employee and the Employer.

The contract also specified that pay would be determined by a Compensation Statement periodically signed by plaintiff. *See* GM's Ex. A. In April of 1961, plaintiff was given a copy of the employee handbook "Working With General Motors" which mentioned GM's policy of filling vacancies by promoting from within whenever possible and which also outlined GM's "Open Door" policy. *See* plaintiff's Ex. 2. Plaintiff received a new

edition of "Working With General Motors" in September of 1977. See GM's Ex. N.

While visiting a GM facility in Framingham, Massachusetts for GM in August of 1961, plaintiff was involved in an automobile accident in which he suffered a back injury. Plaintiff makes unsubstantiated claims that because of his accident, he was treated badly on the job. Following plaintiff's return to work after the accident, he was given an appraisal of D3. See plaintiff's Ex. 1. Plaintiff's injury became the subject of a worker's compensation claim which was ultimately resolved in November of 1966 through plaintiff's exercise of the "Open Door" policy. See GM's Ex. 1 and 2.

During the period from 1966 through 1974 plaintiff received appraisals of B1 and B2. Plaintiff's Ex. 1. Plaintiff continued employment through May 20, 1980. Between 1966 and 1980, plaintiff exercised his rights under the "Open Door" policy numerous times by writing letters expressing an interest in promotion and transfer to a warmer climate. Plaintiff was neither transferred nor promoted. See GM's Ex. 3-11.

Plaintiff submitted a Statement of Claim for Sickness and Accident benefits to Metropolitan on June 2, 1980. The Claim was signed by Andrew T. Yang, Ph.D., who stated that plaintiff was suffering from situational anxiety reaction. Aff. of Richard J. Prunty, Ex. A. In a letter from Dr. Yang to Stephen A. Evanoff, D.O., plaintiff's physician for back problems, Dr. Yang suggested that plaintiff might also be suffering disc problems. On the very day the claim was received, Metropolitan clerk C. Newton notified the Administrator of the Employee Benefit Plan that Dr. Yang held a Ph.D. degree and was not a licensed physician. Ms. Newton then scheduled a psychiatric examination for plaintiff on June 11, 1980 at 1:30 p.m. Aff. of Prunty, Ex. B. On June 5, 1980, Norb Leonard of Metropolitan told Ms. Newton that benefits could be awarded under the certification of a Ph.D. holder only if a psychiatrist concurred in the Ph.D.'s findings of disability. Furthermore, benefits could not be awarded for a back problem without proof that plaintiff was being seen and treated by a physician for the back problem. Aff. of Prunty, Ex. C.

Plaintiff was examined by Metropolitan's psychiatrist, Dr. Forrer, who found plaintiff unable to work. However, six weeks later, Dr. Forrer stated that plaintiff could return to work. Aff. of Prunty, Ex. F. Plaintiff then filed a Supplementary Claim Form seeking disability benefits for orthopedic reasons. Aff. of Prunty, Ex. G. Plaintiff was placed on Special Leave of Absence Without Pay pending a determination of his alleged disability. Aff. of Prunty, Ex. H. Finally, on September 25, 1980, Metropolitan's doctor found that plaintiff was not disabled for orthopedic reasons. Aff. of Prunty, Ex. J. On November 5, 1980, a GM plant doctor found plaintiff able to return to work. Aff. of Prunty Ex. L. Plaintiff did not return to work. Thus, his absence was treated as a voluntary quit and plaintiff's employment, and consequently his insurance coverage, was terminated as of November 5, 1980. GM's Ex. 1; Aff. of Prunty.

Now that Metropolitan has provided the Court with a copy of the insurance policy, its two motions for partial summary judgment are quite easily resolved. It is clear from Section 10 of the insurance policy that benefits will be awarded only if a claimant is treating with a legally licensed physician. Metropolitan's Reply Brief, Ex. A. Furthermore, it is equally evident from the affidavit of Richard J. Prunty, a Senior Consultant in Metropolitan's Litigation and Appeals Department, and exhibits attached thereto, that payments for plaintiff's psychological disability were not made on the basis of Dr. Yang's recommendation, but upon the certification of Dr. Forrer, a psychiatrist. Therefore, plaintiff's theory that Metropolitan is estopped from denying him benefits under the signature of a Ph.D. degree holder because he relied to his detriment on an earlier award based on Dr. Yang's report simply does not fit the facts. Plaintiff has stated no factual basis for his contention that this so-called contract of adhesion should not be enforced. Plaintiff having offered no facts to contradict that which Metropolitan has established, Metropolitan's motion for partial summary judgment on the issue of disability benefits for a psychological condition is GRANTED.

Granted also is Metropolitan's motion for partial summary judgment on the issue of disability benefits for a back condition. Section 10 of the insurance contract provides that an impairment will be treated as a disability when it renders an employee "wholly and continuously disabled" from performing "any and every" job duty. Once again, plaintiff has failed to state a factual basis for his assertion that the contractual definition of disability is intolerably restrictive. Four doctors evaluated plaintiff's back problem. Both Metropolitan's doctor and GM's plant physician opined that plaintiff was able to work. Aff. of Prunty, Ex. J and L. Dr. Stephen A. Evanoff treated plaintiff for his back problem, beginning in 1978. However, Dr. Evanoff, as a treating physician, never considered it necessary to advise plaintiff to quit working, even during the period that plaintiff was seeking disability benefits. In fact, Dr. Evanoff believed that plaintiff was able to work. Dep. of Stephen A. Evanoff, D.O. at 31-38. Only Dr. Max Karl Newman, who examined plaintiff only once in July of 1980, concluded that plaintiff had been disabled since May 20, 1980. In fact, Dr. Newman stated that plaintiff may have been disabled years previous to May 20, 1980, during which time he was employed full-time by GM. Dep. of Max Karl Newman, M.D. at 54. Dr. Newman further declared that plaintiff was disabled from "bending, lifting, twisting, [and] turning." Dep. of Newman at 50. However, plaintiff's November 11, 1983 deposition reveals that the strenuous activity from which Dr. Newman disabled him was not a part of plaintiff's job. Dep. of plaintiff at 8-17 (Nov. 11, 1983). Whether or not plaintiff can bend and twist is irrelevant when the job from which he claims to be disabled has no bending and/or twisting requirements.

The Court will address the issues in GM's motion for summary judgment in the order addressed by GM. GM first argues that plaintiff cannot maintain his Count III claim that his termination of employment on November 5, 1980 was in breach of his contractual employment agreement with GM. Plaintiff bases his claim on *Toussaint v. Blue Cross & Blue*

*Shield of Michigan*, 408 Mich. 579, 292 N.W.2d 880 (1980), in which the Michigan Supreme Court held that an employer's policy statements may give rise to the legitimate expectation of an employee hired for an indefinite period that he will be discharged only for just or good cause. Plaintiff states that the "Open Door" policy described in the pamphlet "Working With General Motors" created the impression that plaintiff's employment would be terminated only for just cause. GM responds that, as provided in paragraph 2 (quoted previously) of the employment agreement, plaintiff's employment was terminable at will, and he could be fired for any cause or no cause. Furthermore, GM argues, the exclusionary language of paragraph 6 of the employment agreement (previously quoted) precludes justifiable reliance on "Working With General Motors." For the reasons stated in *Reid v. Sears, Roebuck and Company*, 588 F.Supp. 558, 563-564 (E.D.Mich.1984), this Court is unpersuaded by GM's arguments that plaintiff does not have a Toussaint claim. Now the Court must turn to a determination as to whether the facts support plaintiff's claim and whether there is any genuine issue of material fact with regard thereto.

Plaintiff asserts that he relied on the representation in the GM pamphlet that job openings would be filled by promotions from within the company, but that he was never promoted beyond a level 7. Dep. of plaintiff at 66-67 (Nov. 11, 1983). Moreover, plaintiff claims that he relied on GM's policy that an open door existed between salaried employees and the supervisory structure, a policy which, GM stressed, epitomized fairness. In particular, plaintiff cites the following paragraph from "Working With General Motors."

In general terms, the policy is simply an attitude of fair and friendly consideration for each individual's viewpoint. More specifically, it invites you to express yourself freely to your supervisor about your job or about General Motors policies. If you have a problem, a misunderstanding or a request, talk to your supervisor about it. If he is not able to give you a satisfactory answer, he will arrange

for your problem to be taken to the proper authority—your general supervisor, the Personnel Department, your General Manager or his designated representative, or, in unusual cases, the General Motors Central Office in Detroit.

See plaintiff's response to GM's Motion for Summary Judgment, Ex. 2. The record reflects that plaintiff freely exercised his rights under the "Open Door" policy, writing letters concerning promotions, transfers, and a workers' compensation claim. GM's Ex. 1-11. The fact that GM did not respond to plaintiff's inquiries with a new job does not raise a question of unfair treatment. Rather, GM cautioned in its pamphlet that "[y]ou should understand, of course, that using the 'Open Door' will not always result in the action you desire. But the Open Door should provide you the opportunity to review your concerns not only with your immediate supervisor but, if necessary, with higher levels of management." GM's Ex. N at 10.

Plaintiff believes that GM's assurances that "an attitude of fair and friendly consideration" to "each individual's viewpoint" create an objective basis for his belief that his employment would be terminated only for just cause. There is absolutely no showing on the record that fairness in terms of the "Open Door" policy meant "just cause" termination. Nor is there any evidence that GM's "Open Door" policy was in any way related to GM's termination policy. The bare allegations of plaintiff's complaint will not survive a motion for summary judgment. Fed.R.Civ.P. 56(e).

At best, plaintiff has described a subjective expectancy of just cause termination. And the Michigan Court of Appeals has held that a subjective expectancy is not sufficient to establish an implied in fact contract. *Schwartz v. Michigan Sugar Co.*, 106 Mich.App. 471, 308 N.W.2d 459 (1981). At worst, plaintiff has suggested an expectancy in continued employment based on the "Open Door" policy, which policy has nothing to do with employment termination. Even if the policy did create a legitimate expectancy of "just cause"

termination, the record establishes that plaintiff was fired after ignoring a letter to return to work after he had been found able to work. The affidavit of Margaret M. Fitzpatrick, Personnel Director, Chevrolet Motor Division, Central Office, states that plaintiff's discharge was in accordance with procedures applicable to GM salaried employees in similar circumstances. Aff. of Fitzpatrick. Therefore, GM's motion for summary judgment on Count III is GRANTED.

As for Count I, the retaliatory discharge claim, GM argues that assuming *arguendo* plaintiff has established a prima facie case, GM has articulated a legitimate, non-discriminatory reason for plaintiff's discharge, a reason which plaintiff has been unable to show was mere pretext. See *Texas Department of Community Affairs v. Burdine*, 450 U.S. 248, 252, 101 S.Ct. 1089, 1093, 67 L.Ed.2d 207 (1981). Here plaintiff claims that he was fired for filing a worker's compensation claim in 1964 and another in 1980 and for pursuing his rights under the "Open Door" policy throughout the 21 years of his employment. GM responds that plaintiff's employment was terminated because he failed to return to work upon notice from GM that he was found able to work. See Aff. of Fitzpatrick. Now "plaintiff must put forth factual allegations to raise a triable issue of fact as to whether [GM's] proffered reason [ ] was [sic] a mere pretext." *Clark v. Uniroyal Corp.*, 119 Mich.App. 820, 826, 327 N.W.2d 372 (1982). The only factual allegations plaintiff makes concerning retaliatory discharge are his subjective beliefs that there was a plot brewing in 1978 to terminate him. Plaintiff does not know who was responsible for the plan, how many were involved in carrying it out, or why they implemented the plan. Dep. of plaintiff at 86-87 (Sept. 23, 1983). Unsupported allegations based on subjective beliefs will not withstand a motion for summary judgment. Fed.R.Civ.P. 56(e).

Finally, plaintiff's failure-to-promote claim is time-barred by the 3-year statute of limitations, M.C.L.A. § 600.-5805(8). Plaintiff last wrote GM concerning promotion in 1977. GM's Ex. 10. However, plaintiff claims to have made oral inquiries

throughout his employment. Dep. of plaintiff at 58-60 (Sept. 23, 1983). He knew as long ago as July of 1971 that he was not being promoted. Dep. of plaintiff at 88-90 (Nov. 11, 1983). But he did not file suit until 1981.

Plaintiff wishes to treat GM's failure to promote as a continuing wrong, and cites various nuisance theory cases in support thereof. While the wrong actually continues in nuisance cases, it is not the failure to promote which continues in employment cases, but the employment itself. And the United States Supreme Court has stated that "[m]ere continuity of employment, without more, is insufficient to prolong the life of a cause of action for employment discrimination." *Delaware State College v. Ricks*, 449 U.S. 250, 257, 101 S.Ct. 498, 504, 66 L.Ed.2d 431 (1980). Thus, any pre-1978 failure to promote claim plaintiff may have had is time-barred. Furthermore, plaintiff has not even attempted to rebut GM's statement, supported by plaintiff's appraisals, that plaintiff's work during the years 1977-80 was not worthy of promotion. GM's Ex. J, K, L, M. Therefore, there has been raised no genuine issue of material fact on either the retaliatory discharge claim or the failure to promote claim, and GM's motion for summary judgment on Count I is GRANTED.

For the reasons just stated, Metropolitan's two motions for partial summary judgment are GRANTED; GM's motion for summary judgment is GRANTED; and this case is DISMISSED.

IT IS SO ORDERED.

## APPENDIX B

### UNITED STATES DISTRICT COURT EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION

Civil Action No. 81-70939

Hon. Charles W. Joiner

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ARTHUR TAYLOR,

*Plaintiff,*

—vs.—

GENERAL MOTORS CORPORATION, a foreign corporation and  
METROPOLITAN LIFE INSURANCE COMPANY, a foreign  
corporation, jointly and severally,

*Defendants.*

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### ORDER DENYING PLAINTIFF'S MOTION TO REMAND

At a session of said Court, held in the Federal Building,  
Detroit, Michigan, on May 4, 1981.

Present: Honorable Charles W. Joiner  
*United States District Judge*

This matter was before the Court on Plaintiff's Motion to Remand. The Court, having reviewed the motion and the briefs of the parties and heard oral argument on the matter:

IT IS HEREBY ORDERED that Plaintiff's Motion to Remand is DENIED.

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CHARLES W. JOINER  
Charles W. Joiner  
*United States District Judge*

## APPENDIX C

UNITED STATES COURT OF APPEALS  
SIXTH CIRCUIT

Argued April 8, 1985

Decided June 7, 1985

No. 84-1503

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 ARTHUR TAYLOR,  
*Plaintiff-Appellant,*

—v.—

 GENERAL MOTORS CORPORATION, and  
Metropolitan Life Insurance Company,  
*Defendants-Appellees.*


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Former employee brought suit against former employer and its insurance carrier alleging breach of contract, retaliatory discharge and wrongful termination of disability benefits. The United States District Court for the Eastern District of Michigan, 588 F.Supp. 562, Stewart A. Newblatt, J., denied employee's motion to remand action to state court and entered judgment for defendants, and employee appealed. The Court of Appeals, Wellford, Circuit Judge, held that was improper.

Reversed and remanded with instructions.

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DENNIS P. BRESCOLL (argued), Mount Clemens, Mich., *for plaintiff-appellant.*

DAVID M. DAVIS (argued), Detroit, Mich., GILBERT Y. RUBENSTEIN (argued), Rubenstein, Pruchnicki, Chittle and Smith, Flint, Mich., *for defendants-appellees.*

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Before:

 WELLFORD and MILBURN, *Circuit Judges,*  
and KINNEARY, *District Judge\*.*


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WELLFORD, *Circuit Judge.*

This action was originally filed by plaintiff, Arthur Taylor, in state court, alleging breach of contract, retaliatory discharge, and wrongful termination of disability benefits. Defendants, General Motors Corporation ("GMC") and Metropolitan Life Insurance Company ("Metropolitan"), thereafter sought to remove the action to federal court under 28 U.S.C. § 1441, asserting that plaintiff's claim for wrongful termination of benefits was in reality a claim under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1145. Plaintiff moved to remand the action to state court, arguing that his claim was based solely on state law and not ERISA. The district court denied plaintiff's motion and subsequently entered judgment for defendants on the merits. 588 F.Supp. 562.

## I.

Plaintiff started at GMC as a salaried employee in 1959 as a fifth level engineering analyst with the Fisher Body Division. In May 1980, following over twenty years of employment and two promotions, plaintiff began experiencing emotional problems allegedly while in the midst of a divorce and child custody

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\* Honorable Joseph P. Kinneary, United States District Court for the Southern District of Ohio, sitting by designation.

dispute. He consulted with a licensed psychologist, Andrew T. Yang, Ph.D., claiming "sheer depression" and "suicidal tendencies." As a result, plaintiff took a leave of absence from work, and also notified Metropolitan, GMC's insurance carrier, that he had become totally disabled. Accompanying this notice was a statement from Dr. Yang that plaintiff was suffering from a "situational anxiety reaction" and should not return to work. In a letter from Dr. Yang to Dr. Stephen A. Evanoff, plaintiff's treating physician, Dr. Yang suggested that plaintiff might be suffering back problems.

Upon receiving plaintiff's notice of disability, Metropolitan commenced paying benefits. At the same time, realizing that Dr. Yang was not a physician, Metropolitan scheduled plaintiff for a psychiatric examination to take place on June 11, 1980. Dr. Gordon Forrer, a licensed psychiatrist, examined plaintiff on this date and concluded that, as an initial matter, plaintiff was to be considered disabled. He recommended, however, that a follow-up examination be held in six weeks. After conducting this follow-up examination, Dr. Forrer concluded that plaintiff was not disabled and could return to work.

Plaintiff then filed a supplementary claim with Metropolitan seeking disability benefits for orthopedic reasons. Plaintiff was placed on special leave of absence without pay pending the outcome of his supplementary claim. In July 1980 plaintiff was directed by Metropolitan to go to the Detroit Industrial Clinic, where he was examined by Dr. N. Wilson. Dr. Wilson, on August 1, 1980, found no orthopedic problems with plaintiff. Later, in September 1980, upon receiving x-rays taken by Dr. Evanoff, Dr. Wilson again concluded that plaintiff suffered no orthopedic problems.

On July 30, 1980, Metropolitan ceased paying plaintiff benefits. On August 12, 1980, plaintiff was informed by GMC that it considered him not to be disabled. On October 10, 1980, Metropolitan informed plaintiff and GMC that it had reviewed the medical evidence and concluded plaintiff was not disabled. It thus refused to pay any benefits beyond July 30, 1980. On October 31, 1980, plaintiff was requested to report to the

Chevrolet Central Office medical department for a medical examination. On November 5, 1980, plaintiff was examined by GMC's physician who concluded that plaintiff was able to resume his duties.

Rather than return to work as requested, plaintiff insisted that he was disabled. On November 10, 1980, plaintiff was notified by GMC that his employment had been terminated as of November 5. His status was reported as a "voluntary quit."

## II.

As a basis for the removal of this case to federal court, GMC and Metropolitan rely wholly on the argument that ERISA preempts state law, and converts plaintiff's state law claim for disability benefits against Metropolitan into a claim under ERISA. The group insurance policy at issue in this case is a part of GMC's employee benefits program established under ERISA. See 29 U.S.C. 1002(1). Because the plan at issue is regulated by ERISA, and because ERISA preempts all state laws in this field, see 29 U.S.C. § 1144, defendants argue that plaintiff's action in reality "arises under" federal law, and hence is subject to removal under 28 U.S.C. § 1441(b).

Plaintiff, on the other hand, asserts that his claim against Metropolitan is only a state law claim. He argues that the claim is based solely on state contract law as a claim for benefits due under a group insurance policy. Because the *complaint* fails to state a federal claim, plaintiff claims the case does not "arise under" federal law within the meaning of either 28 U.S.C. § 1331 or 28 U.S.C. § 1441, and could not properly be removed.

Both plaintiff's and defendants' arguments find support in the case law. Several district courts have found removal proper under circumstances analogous to those presented here. See, e.g., *Leonardis v. Local 282 Pension Trust Fund*, 391 F.Supp. 554, 557 (E.D.N.Y.1975) ("Actions of which the District Courts have original jurisdiction are not subject to remand irrespective of whether the plaintiff intended to allege a federal or state claim, if a federal cause of action exists"); *Tolson v.*

*Retirement Committee of the Briggs & Stratton Retirement Plan*, 566 F.Supp. 1503 (E.D.Wis.1983) (court finds state contract claim for benefits preempted by ERISA and thus removal was proper).

In *Roe v. General American Life Insurance Co.*, 712 F.2d 450 (10th Cir.1983), moreover, an employee brought suit in state court against his employer and its insurer alleging that certain benefits were due him under the employer's employee benefits plan. The district court found removal proper, because the plan at issue was regulated by ERISA. The Tenth Circuit agreed:

Recognizing that there is some split of authority, we believe that the insurance program of the sort here involved does come within the ambit of ERISA, and that the case was properly removed.

*Id.* at 452.

As noted by the Tenth Circuit, a definite split of authority exists. See, e.g., *Lederman v. Pacific Mutual Life Insurance Co.*, 494 F.Supp. 1020 (C.D.Cal.1980) (court finds removal improper because plaintiff given choice of forum). In *Powers v. South Central United Foods & Commercial Workers Unions and Employees Health and Welfare Trust*, 719 F.2d 760 (5th Cir.1983), a participant in a jointly trusted employee health and welfare plan, subject to ERISA, brought suit in state court alleging the plan had fraudulently misrepresented its coverage and had violated the Texas Deceptive Trade Practices Consumer Protection Act. The case was removed to federal district court on the ground that the plan was controlled solely by ERISA. On appeal, the court found that removal was improper, entering into a well-thought analysis of removal jurisdiction.

Whether a case is one rising [sic] under the Constitution or a law or treaty of the United States, . . . must be determined from what necessarily appears in the plaintiff's statement of his own claim . . . , unaided by any-

thing alleged in anticipation or avoidance of defenses which it is thought the defendant may interpose.

*Id.* at 763 (quoting *Taylor v. Anderson*, 234 U.S. 74, 75-76, 34 S.Ct. 724, 724-725, 58 L.Ed. 1218 (1914)). "[A] defendant may not remove a case to federal court unless the plaintiff's complaint establishes that the case 'arises under' federal law." 719 F.2d at 764 (quoting *Franchise Tax Board of California v. Construction Laborers Vacation Trust for Southern California*, 463 U.S. 1, 103 S.Ct. 2841, 2847, 77 L.Ed.2d 420 (1983)). Moreover, "an asserted or anticipated defense predicated on federal preemption of state law is, in jurisdictional terms, a defense like any other, and will not serve to invoke federal jurisdiction." 719 F.2d at 264.

The Supreme Court has recently reiterated this point in an ERISA-preemption context. In *Franchise Tax Board*, 103 S.Ct. at 2848, the Court stated that a

case may not be removed to federal court on the basis of a federal defense, including the defense of preemption, even if the defense is anticipated in the plaintiff's complaint, and even if both parties admit that the defense is the only question truly at issue in the case.

That case involved the attempted removal of a claim brought by a state agency seeking to collect delinquent taxes from a benefit plan. Removal was based solely on preemption under ERISA. The Court concluded that removal was improper because the complaint, as opposed to the defense, failed to make out a federal claim.

Applying the *Franchise Tax Board* rationale, the *Powers* court concluded that the case before it was not removable because it "alleged no federal cause of action, raised no federal issue, and relied on no federal statute." 719 F.2d at 765. Likewise, in the present case plaintiff has not asserted a federal claim. The federal question relied on for removal is based upon Metropolitan's defense. Although the issue is certainly not free from doubt, we are persuaded that plaintiff has confined his

claim against Metropolitan to one based on state law, and the well-pleaded complaint rule precludes removal.

This case is not a case where the plaintiff has "artfully" fail[ed] to plead essential federal issues in the complaint," *id.* (citing *Franchise Tax Board*, 103 S.Ct. at 2853), in order to avoid federal jurisdiction. Further, we do not believe this is a situation where "the plaintiff's complaint clearly establishes that the claim is one necessarily rising [sic] under federal law," 719 F.2d at 766, justifying removal jurisdiction. It is not "clearly established" that actions for benefits allegedly due under a group insurance policy "necessarily" arise under federal law simply because the insurance policy is a part of an overall benefit plan established pursuant to ERISA. *See Cate v. Blue Cross & Blue Shield of Alabama*, 434 F.Supp. 1187 (E.D.Tenn.1977) (action against group insurer for benefits held not to constitute federal claim merely because insurance agreement was part of plan regulated by ERISA); *Eversole v. Metropolitan Life Insurance Co.*, 500 F.Supp. 1162 (C.D.Cal.1980) (claim for medical benefits allegedly due under group policy not preempted by ERISA); *Home for Crippled Children v. Prudential Insurance Co.*, 590 F.Supp. 1490 (W.D.Pa.1984) (action against group insurer not necessarily governed by ERISA); *cf. Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir.1982) (en banc) (group insurance plan not in and of itself employee benefit plan within meaning of ERISA).

We express no opinion concerning whether Congress intended ERISA to preempt the type of claim brought by plaintiff in this case.<sup>1</sup> Rather, we hold only that removal was improper where the well-pleaded complaint in this instance

<sup>1</sup> This court recently held that ERISA was intended to preempt a common law cause of action for wrongful discharge. *Authier v. Ginsberg*, 757 F.2d 796 (6th Cir.1985). Our holding today is not inconsistent with that result. In *Authier* the court was concerned not with whether it had jurisdiction, but with the substance of the asserted preemption defense. In contrast, we here are concerned not with the merit of the preemption defense, but rather with whether jurisdiction exists in the first instance. The questions are separate and distinct.

failed to raise a federal question.<sup>2</sup> There is also no diversity basis of jurisdiction,<sup>3</sup> and therefore the case must be remanded to state court.<sup>4</sup>

We recognize that as a general rule courts permit removal to federal court, notwithstanding the well-pleaded complaint doctrine, where an employee in a labor case attempts to assert a common law cause of action against his employer. *See, e.g., Olguin v. Inspiration Consolidated Copper Co.*, 740 F.2d 1468 (9th Cir.1984) (contract claim against employer preempted by Labor Management Relations Act thus making removal proper). In those cases, however, regardless of the wording of the complaint it is clear that the claim must necessarily arise under federal law. Any attempt by the plaintiff to circumvent federal labor law is merely a practice in artful pleading. *See Eitmann v. New Orleans Public Service, Inc.*, 730 F.2d 359 (5th Cir.), *reh'g denied*, 738 F.2d 437 (5th Cir.), *cert. denied*, \_\_\_ U.S. \_\_\_, 105 S.Ct. 433, 83 L.Ed.2d 359 (1984). We, like the Fifth Circuit in *Powers* and *Eitmann*, find cases implicating ERISA to differ from those involving the federal labor laws generally.

### III.

We REVERSE the judgment of the district court and REMAND with instructions to transfer this case to the state court. We, of course, express no opinion in regard to the merits of plaintiff's various claims discussed fully by the district court.

<sup>2</sup> We recognize that the well-pleaded complaint doctrine, established in *Louisville & Nashville Railroad Co. v. Mottley*, 211 U.S. 149, 29 S.Ct. 42, 53 L.Ed. 126 (1908), is a rule of statutory origin, and is not a constitutional mandate.

<sup>3</sup> Plaintiff is a citizen of Michigan, as is GMC for diversity purposes.

<sup>4</sup> A claim brought by a participant or beneficiary to recover benefits due under the terms of an employee benefit plan may be brought in either state or federal court. *See* 29 U.S.C. §§ 1132(a)(1)(B) and 1132(e)(1). Thus, even if the claim presented here were brought under ERISA it could be pursued in state court.

## APPENDIX D

UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

No. 84-1503

FILED—JUL 25, 1985—JOHN P. HEHMAN, *Clerk*

—★—

ARTHUR TAYLOR,  
*Plaintiff-Appellant,*

—v.—

GENERAL MOTORS CORPORATION, ETC. et al.,  
*Defendants-Appellees.*

—★—

Before:

WELLFORD and MILBURN, *Circuit Judges,*  
and KINNEARY\*, *United States District Judge.*

—★—

## ORDER

The Court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this Court, and no judge of this Court having requested a vote on the

\* Hon. Joseph P. Kinneary, sitting by designation from the Southern District of Ohio.

suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ JOHN P. HEHMANJohn P. Hehman, *Clerk*

## APPENDIX E

STATE OF MICHIGAN  
IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

---

ARTHUR TAYLOR,

*Plaintiff,*

—vs.—

GENERAL MOTORS CORPORATION, a foreign corporation and  
METROPOLITAN LIFE INSURANCE COMPANY, a foreign  
corporation, jointly and severally,

*Defendants.*

---

COMPLAINT

NOW COMES Plaintiff, ARTHUR TAYLOR, by and through his attorneys, DONNELLY & ASSOCIATES, P.C., and for his complaint against Defendants, GENERAL MOTORS AND METROPOLITAN LIFE INSURANCE COMPANY, alleges as follows:

## COUNT 1

1. That Plaintiff is a resident of the City of Flint, County of Genessee, State of Michigan.

2. That General Motors is a Delaware Corporation with its principal place of business in Michigan and Metropolitan Life Insurance Company is a New York Corporation licensed to do business in Michigan.

3. That the amount in controversy exceeds Ten Thousand (\$10,000.00) Dollars or is otherwise within the jurisdiction of the Court.

4. That on or about July of 1955, Plaintiff accepted General Motor's offer of employment and agreed to furnish his services as an engineer in General Motors Corporation.

5. That in August of 1961, Plaintiff was involved in an automobile accident which occurred in the course of Plaintiff's employment with General Motors Corporation.

6. That as a direct and proximate result of said accident, Plaintiff suffered injuries to his back, neck, head and legs.

7. That despite the treatment and medical attention Plaintiff received immediately after the accident, Plaintiff has been hospitalized on numerous occasions since the date of the accident, has been treated and examined by numerous doctors and specialists, and has made every reasonable effort to correct his back and neck problem.

8. That Plaintiff has been diagnosed as having degenerative osteoarthritis of the cervical and lumbosacral spine, a permanent medical impairment which limits Plaintiff's walking, standing, climbing, etc. . .

9. That Plaintiff's doctors, supported by numerous consulting specialists, have pronounced Plaintiff totally disabled from returning to normal and customary work duties with General Motors Corporation.

10. That prior to Plaintiff's condition becoming totally disabling, his doctors placed travel restrictions on Plaintiff and also recommended that he move to a warm, dry climate for therapeutic trial to live for at least six months.

11. That each and every work restriction placed on Plaintiff from a medical standpoint was met with greater resistance and harrassment from departmental management at General Motors, i.e., after Plaintiff's doctors recommended a transfer to a warm, dry climate, management at General Motors attempted to transfer Plaintiff to a cold, damp warehouse.

12. That Plaintiff has filed a Worker's Compensation claim with General Motors, and submitted to medical examination by General Motor[s'] doctors.

13. That after brief and superficial examinations by General Motor[s'] doctors, they concluded Plaintiff's medical condition had improved to the level where Plaintiff could again report to work, despite extensive medical documentation and evidence to the contrary.

14. That Plaintiff was terminated from his position with General Motors on November 5, 1980, allegedly for failing to report back to work as ordered by General Motors.

15. That the actual reason for Plaintiff's discharge was two-fold: (a) Plaintiff's serious medical condition required medical restrictions to be placed on him, restrictions which General Motors objected to; (b) Plaintiff filed a worker's compensation claim for his total disability with General Motors, and General Motor[s'] firing of the Plaintiff was in retaliation for filing said claim.

16. That General Motor[s'] discharge of Plaintiff because of medical restrictions placed on him and in retaliation for filing a workers compensation case are against the public policy of this state.

17. That because of General Motor[s'] retaliatory discharge, Plaintiff has been greatly damaged in that he lost pay compensation, all benefits and insurance coverages, and has suffered loss of esteem among family and friends, and humiliation, all to his great detriment.

WHEREFORE, Plaintiff prays for a judgment that is both fair and equitable, including compensatory and exemplary damages in excess of Ten Thousand (\$10,000.00) Dollars and interest thereon, plus costs and attorney fees.

## COUNT II

For Count II of his Complaint, Plaintiff alleges as follows:

18. That Plaintiff hereby adopts and incorporates by reference, each and every allegation contained in paragraphs one (1) through (17) of Count I herein as paragraph eighteen of Count II.

19. That pursuant to Plaintiff's employment agreement with General Motors, General Motors agreed to provide certain benefits and insurance coverages to Plaintiff.

20. That the premium for said benefits and insurance policies were paid by General Motors for Plaintiff's benefit.

21. That the following were provided through the Metropolitan Life Insurance Company to Plaintiff:

- (a) Basic Group Life Insurance and Extra Accident Insurance  
(Group Policy No. 14000-G)
- (b) Survivor Income Benefit Insurance  
(Group Policy No. 22500-G)
- (c) Sickness and Accident Insurance and Extended Disability Benefit Insurance  
(Group Policy No. 18501-G)

22. That said Sickness and Accident Insurance Policy, effective date 1977, provides that in the event of total disability and the inability to work, certain monthly benefits were to be paid.

23. That the 1980 General Motor[s] personnel benefit summary stated that in the event of total disability, Plaintiff was entitled to receive salary continuation and/or disability benefits of Two Thousand Four Hundred and Sixty-Two (\$2,462.00) Dollars per month for twenty-six (26) weeks and One Thousand Eight Hundred and Thirteen (\$1,813.00) Dollars per month for the next twenty-seven (27) weeks.

24. That on July 30, 1980, when said Sickness and Accident Insurance Policy was in full force and when Plaintiff was totally disabled and depend[en]t on said monthly benefits for his entire income, Metropolitan Life Insurance Company wrongfully and maliciously discontinued said insurance coverage in breach of the insurance contract.

25. That due notice of Plaintiff's disability was given to the insurer, Metropolitan Life, and Plaintiff has duly performed all the conditions of said policy on his part.

26. That the termination of disability payments has caused Plaintiff great financial hardship and left Plaintiff unable to adequately provide for or support himself and his two minor sons, for whom Plaintiff is sole legal guardian.

27. That as a result of the improper discontinuance of said benefits, Plaintiff has suffered great mental anguish due to the real and distinct possibility that Plaintiff will lose custody of his two sons.

28. That this is a real possibility because Plaintiff lacks the means to adequately support them and provide for their basic human and medical needs.

29. That Plaintiff's back condition prevents him from gaining other meaningful employment.

WHEREFORE, Plaintiff prays for a judgment that is both fair and equitable, said judgment consisting of compensatory damages for money contractu[a]lly owed Plaintiff, compensation for mental anguish caused by breach of this contract, as well as immediate reimplementat[i]on of all benefits and insurance cov-

erages Plaintiff is entitled to, together with interest thereon, costs and attorney fees.

Respect[fully] submitted,

By: \_\_\_\_\_  
 V. PAUL DONNELLY (P 12879)  
 Attorney for Plaintiff  
 2056 City National Bank Bldg.  
 Detroit, Michigan 48226  
 (313) 963-4200

---

#### DEMAND FOR JURY TRIAL

NOW COMES Plaintiff, ARTHUR TAYLOR, by and through his attorneys, Donnelly & Associates, P.C., and hereby demands a trial by jury.

DONNELLY & ASSOCIATES, P.C.

By: \_\_\_\_\_  
 V. PAUL DONNELLY (P 12879)  
 Attorney for Plaintiff  
 2056 City National Bank Bldg.  
 Detroit, Michigan 48226  
 (313) 963-4200

## APPENDIX F

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

84 Civ. 9170(CES)

RECEIVED—Sep - 6 1985—VPKK & D

—\*—  
LAWRENCE A. TESTA,

*Plaintiff,*

—against—

CIBA-GEIGY CORPORATION,

*Defendant.*

—\*—  
MEMORANDUM DECISION

STEWART, *District Judge:*

Plaintiff brought suit in the Supreme Court of the State of New York at Orange County, alleging, in essence, that his benefits under defendant's long-term disability plan were improperly terminated. Defendant filed a petition for removal, which plaintiff opposes; defendant also moves to dismiss under Fed. R. Civ. P. 12(b)(6). For the reasons stated below, defendant's motions both for removal and for dismissal are granted.

*Background*

Plaintiff Lawrence A. Testa was initially employed by defendant CIBA-GEIGY Corporation in April 1974, finally holding the position of "Industry Sales Manager." In October 1976,

plaintiff was injured in a traffic accident as a result of which he was placed in a "Vocational Rehabilitation Program" in March 1973, with reduced salary and job responsibilities. In September 1978, plaintiff was characterized as long-term disabled under defendant's benefits program (the "Plan") and his salary was reduced to fifty percent of his full salary.

On May 27, 1983, defendant's Director of Corporate Employee Benefits notified plaintiff that his benefits would be discontinued if he did not undergo vocational rehabilitation services as required by the Plan. Plaintiff acquiesced in this demand. It was apparently at this time, however, that defendant learned that plaintiff was running a consulting practice. On November 7, 1983, plaintiff's benefits were terminated, allegedly because he no longer fit the Plan definition of "disabled." Plaintiff contends that the termination violated the terms of the Plan or, alternatively, was based upon a version of the Plan amended after his benefits had vested. Plaintiff also alleges that defendant acted maliciously and in bad faith in order to avoid its contractual obligations.

*Federal Subject Matter Jurisdiction*

Defendant's premise for removal jurisdiction is that the complaint seeks clarification of plaintiff's rights to future benefits under an "employee welfare benefit plan" and is therefore a civil action within the meaning of § 582 of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132. Plaintiff contends that defendant's long-term disability plan is not within the ambit of ERISA. Alternatively, he argues that the concurrent jurisdiction provided by ERISA demands that the case be tried in state court, despite defendant's right to remove. As a preliminary matter, then, we must determine whether the Plan is governed by ERISA at all.

ERISA was enacted by Congress in 1974 to protect the interests of employees in their corporate benefit plans. 29 U.S.C. § 1001. It provides that all "employee welfare benefit plan[s]" are governed by its regulations, defines an "employee welfare benefit plan" as, in relevant part, "any plan, fund, or

program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . benefits in the event of . . . disability." 29 U.S.C. § 1002(1). Accordingly, any plan meeting this definition is governed by ERISA, and the federal courts may have subject matter jurisdiction over disputes arising thereunder. 29 U.S.C. § 1003.

Defendant's "Summary Plan Description" ("SPD") specifically states that the CIBA-GEIGY benefit plans are governed by ERISA.<sup>1</sup> In part, the Plan's purpose is "to provide income protection to salaried employees should they become unable to earn a living because of extended disabilities due to illness or accident." Long-Term Disability Plan, Roesch Aff., Ex. A at 1. Accordingly, we agree with the recent Fourth Circuit decision which specifically noted that CIBA-GEIGY's plan is covered by ERISA. *Berry v. CIBA-GEIGY Corp.*, 761 F.2d 1003, 1007 (4th Cir. 1985).

Plaintiff's contention that this action does not "arise under" ERISA is also without merit, as the statute allows an employee to bring a civil action "to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a). Plaintiff's complaint in this action seeks damages "representing the amount to which plaintiff would have been entitled and *will be entitled in the future*, had defendant's breach not taken place." Complaint ¶¶ 29, 30 (emphasis added). Accordingly, it is clear that despite his contentions to the contrary, plaintiff has stated a cause of action "arising under" ERISA, thereby providing federal subject matter jurisdiction.

Plaintiff's argument that this action does not arise under ERISA because Section 8.3 of defendant's Long-Term Disability Plan states that it shall be "construed and its provisions enforced and administered in accordance with the laws of the State of New York," Roesch Aff. ¶ 14, is without merit. The argument suggests that the employer could exempt itself from

1. Both the SPD and the Plan itself are required to be available to beneficiaries. 29 U.S.C. § 1021; 29 C.F.R. § 2520.102-3(t)(2).

ERISA through a simple choice of law clause, which would be an untenable interpretation of a statute intended to protect employees. Here, the fiduciary argues that the choice of law clause was intended for those issues not specifically governed by federal law. This seems to be the more logical interpretation, and consistent with the SPD's written reference to ERISA.

Regardless of the face of his complaint, plaintiff seeks to clarify his rights to future benefits under the plan and is thus seeking a remedy that necessarily "arises under" federal law. The argument that the dispute does not "arise under" federal law merely relies on artful pleading and is insufficient to circumvent the existence of federal subject matter jurisdiction. *See Gold v. Blinder, Robinson & Co., Inc.*, 580 F. Supp. 50, 53 (S.D.N.Y. 1984); *Calhoun v. Bonnabel*, 560 F.Supp. 101 (S.D.N.Y. 1982); *cf. Federated Department Stores v. Moitie*, 452 U.S. 394, 397 n.2 (1981) (artful pleading may not defeat defendant's right to federal forum, and court should look beyond plaintiff's characterization of claim to determine its real nature).

In the alternative, plaintiff contends that state and federal courts are granted concurrent jurisdiction over actions to recover benefits or to enforce rights under the plan, 29 U.S.C. § 1132(e)(1), and argues that the case should be remanded because he "should be permitted to litigate his causes of action in the forum of his choice." Roesch Aff. ¶ 1. However, plaintiff has directed the court to no precedent in support of his position and there is little to recommend it. Removal is permitted "[e]xcept as otherwise expressly provided by Act of Congress." 28 U.S.C. § 1441(a). The failure of the legislature to prohibit removal in ERISA suits is indicative of an intent to permit it. *See Butler v. Rye*, 544 F. Supp. 143, 145 (W.D. Mo. 1982) (considering removal under TILA, 28 U.S.C. § 1640(e)); *McConnell v. Marine Engineers Beneficial Association*, 526 F. Supp. 770 (N.D.Cal.1981) (considering removal under ERISA); *Colin K. v. Schmidt*, 528 F. Supp. 355 (D.R.I. 1981) (considering removal under EAHCA, 20 U.S.C. § 1415(e)(2));

*Sicinski v. Reliance Funding Corp.*, 461 F.Supp. 649 (S.D.N.Y. 1978) (considering removal under RESPA, 12 U.S.C. § 2614, and TILA, 15 U.S.C. 1640(e)); *Leonardis v. Local 282 Pension Trust Fund*, 391 F. Supp. 554 (E.D.N.Y. 1975) (considering removal under ERISA). Thus, the concurrent jurisdiction created by ERISA for this type of case entitles defendant to remove to federal court. 28 U.S.C. § 1132(f).

Plaintiff's argument that defendant has waived this right is unconvincing. Commentators have noted that "[w]aiver of right to removal is still possible but defendant's intent must be clear and unequivocal." 1A Moore's Federal Practice § 0.157[9]. Indeed, even answering the complaint in state court is not clear enough evidence of the intent to waive. *See Harris v. Brooklyn Dressing Corp.*, 560 F. Supp. 940 (S.D.N.Y. 1983). Accordingly, neither the previously discussed choice of law clause, nor a statement in the SPD that an employee with a claim for benefits may bring suit in either state or federal court demonstrates this clear and unequivocal intent.

In *Wiesenberger Services, Inc. v. Response Analysis Corp.*, 365 F. Supp. 258 (S.D.N.Y. 1973), Judge Knapp held that a clause worded almost identically to the clause before us here, and containing an agreement by both parties to waive objections to the *in personam* jurisdiction of the courts of New York did not preclude a federal court sitting in New York from exercising jurisdiction. Moreover, in another case interpreting a similar clause,<sup>2</sup> Judge Weinfield held that "if 'New York courts' can mean both federal and state courts, it should be so construed unless express and restrictive language indicates otherwise." *City of New York v. Pullman Corp.*, 477 F. Supp. 438, 442 (S.D.N.Y. 1979). A mere choice of law clause cannot

2. The clause provided that

[t]his contract is to be construed pursuant to the laws of the State of New York and the undersigned bidder agrees that only the New York courts shall have jurisdiction over this contract and any controversies arising out of this contract.

*City of New York v. Pullman Corp.*, 477 F. Supp. 438, 440 (S.D.N.Y. 1979).

be construed as a choice of forum clause, and thus it does not constitute a waiver of defendant's right to remove.

Similarly, the statement in the SPD that "[i]f you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in State or Federal Court" is no indication of defendant's intent to waive its right of removal. This statement is merely a *verbatim* quote from the Department of Labor Regulations, 29 C.F.R. § 2520.102-3(t)(2), and must be included as an enunciation of participants' rights under ERISA. Mere compliance with federal regulations cannot be construed as an intent to waive any rights. *Cf. Kelbert v. Travelers Insurance Co.*, 245 F. Supp. 31 (S.D.N.Y. 1965) (agreement not to remove, which merely complies with state law requirement for doing business could not be construed as a waiver of right to remove). Accordingly, jurisdiction over this matter may properly lie with the federal courts.

### Dismissal

Having determined that this court may retain jurisdiction, it is now necessary to reach the issue of dismissal under Rule 12(b)(6) for failure to exhaust administrative remedies.

ERISA requires that all employee welfare plans provide for notice of denial of benefits and an opportunity for an administrative hearing. 29 U.S.C. § 1133. Although there is no statutory requirement that the beneficiary exploit these hearings, most circuits require the administrative remedies be exhausted prior to the bringing of a federal suit. *See Mason v. Continental Group, Inc.*, 763 F.2d 1219 (11th Cir. 1985); *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182 (3d Cir. 1984); *Kross v. Western Electric Co.*, 701 F.2d 1238 (7th Cir. 1983); *Amato v. Bernard*, 618 F.2d 559 (9th Cir. 1980).

While this Circuit has not yet ruled on the issue, Judge Bonsal addressed it while sitting by designation with the Seventh Circuit. Although he dissented from part of the opinion, he concurred that the best approach was to follow "well-established federal policy, and supporting case law, favoring exhaustion of administrative remedies prior to bring-

ing an ERISA-based lawsuit in federal court." *Western Electric Co.*, *supra*, 701 F.2d at 1245.

Other courts have provided sound reasoning for this requirement, noting that the administrative claim procedures of ERISA were intended to filter out frivolous suits, minimize settlement costs for all parties involved, and create a non-adversarial method of claims settlement. *Taylor v. Bakery & Confectionary Union & Industry International Welfare Fund*, 455 F.Supp. 816, 820 (E.D.N.C. 1978). Moreover, courts within this circuit have noted in similar contexts that this requirement promotes judicial economy and exploits the administrative agency's expertise in its subject area. See *T.I.M.E.-DC, Inc. v. Trucking Employees of New Jersey Welfare Fund*, 560 F. Supp. 294 (E.D.N.Y. 1983); *White v. Shull*, 520 F. Supp. 11 (S.D.N.Y. 1981). Indeed, after arguing by analogy to the Labor-Management Relations Act of 1947 and examining the legislative history of ERISA, the Ninth Circuit noted that "[i]t would certainly be anomalous if the same good reasons that presumably led Congress and the Secretary to require covered plans to provide administrative remedies for aggrieved claimants did not lead the courts to see that those remedies are regularly used." *Amato, supra*, 618 F.2d at 567.

While an exhaustion requirement is discretionary with the court, *Buzzard v. Local Lodge 1040 International Association of Machinists & Aerospace Workers*, 480 F.2d 35, 41 (9th Cir. 1973), plaintiff has given this court no reason to believe that a resort to administrative remedies would be futile, see *Schneider v. U.S. Steel Corp.*, 486 F. Supp. 211 (W.D. Pa. 1980), or that it would create undue hardship, see *ITT Continental Baking Co. v. United States*, 559 F. Supp. 454 (S.D.N.Y. 1983). Indeed, where, as here, there is some disagreement as to the basic questions at issue,<sup>3</sup> there is clearly great benefit to be

3. Plaintiff argues that the termination of benefits was related to his earlier temporary refusal to undergo rehabilitative training, and that since he subsequently underwent this training, he should still be eligible. Defendant contends, however, that this incident had nothing to do with the termination of benefits, but rather that plaintiff is no longer permanently disabled.

derived from the clarification that would result from an administrative hearing.

Because judicial review of administrative decisions follows the "arbitrary and capricious" standard, *Miles v. New York State Teamsters Conference Pension & Retirement Fund Employee Pension Benefit Plan*, 698 F.2d 593, 599 (2d Cir. 1982), *cert. denied*, 104 S. Ct. 105 (1983); *Pompano v. Michael Schiavone & Sons, Inc.*, 680 F.2d 911, 915 (2d Cir.), *cert. denied*, 459 U.S. 1039 (1982), it may be that most plaintiffs would prefer to take their actions immediately to the federal courts. However, it is apparent that Congress did not intend this result when enacting ERISA. Where other remedies are available, it is not unreasonable to require that the federal courts be the remedy of last resort. Accordingly, this action must be dismissed for failure to exhaust administrative remedies.

SO ORDERED.

/s/ CHARLES E. STEWART, JR.  
United States District Judge

Dated: New York, New York  
September 3, 1985

## APPENDIX G

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

No. 82-40304

HON. STEWART A. NEWBLATT

---

ARTHUR TAYLOR,

*Plaintiff,*

—vs.—

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

---

REPLY BRIEF OF METROPOLITAN LIFE INSURANCE  
COMPANY IN SUPPORT OF . . . ITS SECOND MOTION  
FOR PARTIAL SUMMARY JUDGMENT AS TO  
PLAINTIFF'S CLAIM FOR DISABILITY RESULTING  
FROM ALLEGED PSYCHOLOGICAL CONDITION

## INTRODUCTION

Plaintiff's response to this motion essentially raises two arguments. First, that the Court should ignore the plain meaning of the words in the policy (requiring treatment by a physician legally licensed to practice medicine), for the reason that the insurance contract at issue is a "contract of adhesion" and its language is contrary to the policyholder's "reasonable expectations". Second, that the Defendant is estopped from

enforcing the policy language by application of the theory of detrimental reliance.

Both of these arguments are without merit. See Metropolitan's brief dated January 10, 1984 and the discussion below.

## DISCUSSION

## I. THE POLICY LANGUAGE MUST BE ENFORCED.

The subject policy clearly and unambiguously requires that the Plaintiff be treated for his alleged disability "by a physician legally licensed to practice medicine". Plaintiff has admitted that Dr. Yang is not such a physician, but would have this Court disregard that fact.

Plaintiff's brief seems to suggest that Courts can ignore policy requirements at will simply because insurance contracts are generally considered to be "contracts of adhesion", quoting only a hornbook, and no Michigan case, to that effect. As discussed in Metropolitan's prior brief, the fact that a contract may be one of "adhesion" has significance only where it contains an ambiguity, in which case the Court can and should resolve the ambiguity in favor of the policyholder. However, in this case there is no ambiguity in the language.

More importantly, the insurance policy at issue in this case is *not* a "contract of adhesion". The insurance coverage provided to salaried employees of General Motors is patterned after the insurance coverage provided to hourly workers, which in turn is *negotiated* during collective bargaining between General Motors Corporation and the U.A.W. In fact, the requirement that the employee be "under treatment by a physician legally licensed to practice medicine" is taken verbatim from the hourly employees' collectively-bargained insurance agreement. See the 1979 Hourly Employees Group Policy Insurance Certificate which was in effect when Plaintiff last worked, the pertinent Sickness and Accident section provisions of which are attached hereto as Exhibit A. Therefore, there is no analogy in this case to the more common "take-it-or-leave-it"

situation which exists in the case of a lone individual attempting to obtain insurance from a "big insurance company".

Plaintiff's brief further suggests that a policyholders "reasonable expectations" should be given effect. However, there is no Michigan case cited for this proposition, nor is there any explanation of how a "reasonable" policyholder could "expect" a clear and unambiguous policy requirement to mean exactly the opposite of what it says. The only insurance coverage any General Motors employee can reasonably expect to be provided by the Metropolitan group policy issued to General Motors is that which actually ends up in the policy. All the employee has to do is read the policy, which the Plaintiff in this case has acknowledged he did.

Plaintiff's citation of *Strible v. Occidental Life Insurance Co.*, which is a Minnesota, not a Michigan, decision, has no application to the facts of this case. In *Strible* the Court was dealing with an insurance policy which required not only treatment by a legally qualified physician (which existed in that case), but also continuous confinement within the patient's house (which requirement was not met). In that case, the Court was confronted with a peculiar fact situation in which the two requirements were internally inconsistent. The treatment by the physician in that case required the Plaintiff to go out of the house and work as part of his prescribed therapy for his particular affliction. Under those unusual circumstances, the Court allowed recovery. There is no such internal conflict involved in the policy language in this case.

## II. METROPOLITAN IS NOT ESTOPPED FROM ENFORCING THE POLICY LANGUAGE.

Plaintiff's second argument is that Metropolitan is estopped from relying upon the policy language requiring treatment by a physician because Defendant "indicated to Plaintiff that Dr. Yang's qualifications were sufficient". Metropolitan Life Insurance Company never did any such thing.

Metropolitan merely paid benefits to the Plaintiff for that period of time during which Metropolitan was either under the impression that Dr. Evanoff (a physician legally licensed to practice medicine) was involved in Plaintiff's treatment for p[s]ychological problems, or was advised by its own independent medical examiner (Dr. Forrer, also a physician legally licensed to practice medicine) that the Plaintiff was temporarily disabled by his psychological problems. As already set forth in Metropolitan's original brief, and the Affidavit of Mr. Prunty, the benefits which were paid to Plaintiff were based upon these other facts, and not upon Dr. Yang's certification.

Plaintiff claims that Metropolitan never informed him that Dr. Yang was unqualified to treat him. Dr. Yang was a psychologist, and Plaintiff had a right to counsel with a psychologist if he wished to do so. Psychologists are qualified to do what they do. But they aren't physicians, and they aren't licensed to practice medicine, and Plaintiff knew that. Therefore, Metropolitan was under no duty, and indeed had no right, to tell Plaintiff Dr. Yang was not qualified to treat him.

Plaintiff cites two Michigan Court of Appeals decisions, *Schipani v. Ford Motor Company* and *Pursell v. Wolverine-Pentronix, Inc.*, as authority for the argument that the doctrine of promissory estoppel applies to this case. However, neither of those cases has any application to the facts of this action. Both of those cases were employment contract cases, rather than insurance contract cases. Both dealt with a specific affirmative representation by the employer to the employee (in *Pursell* that the employee would be retained until he attained age 65, and in *Schipani* that the employee would not be discharged without cause). Both dealt with the employee's ability to enforce the oral promise, despite a defense based upon the statute of frauds, in view of the fact that the employee relied to his detriment upon the specific promise made by the employer. In this case, Metropolitan made no specific representation to the Plaintiff; it merely paid him benefits for a short period of time. In this case, the

Plaintiff did not give up his job, as in Pursell, or in any other way change his prior course of conduct to his detriment in reliance upon Metropolitan's payment of benefits. He merely continued to counsel with Dr. Yang as he had always done.

CONCLUSION

The specific policy language must be enforced, and Plaintiff's claims must be dismissed.

Respectfully submitted,

RUBENSTEIN PRUCHNICKI CHITTLE  
& SMITH

/s/ THOMAS E. CHITTLE  
Thomas E. Chittle

Dated: 2-15-84

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# **OPPOSITION BRIEF**

Supreme Court, U.S.  
**FILED**

**JAN 17 1986**

JOSEPH F. SPANIOL, JR.  
CLERK

No. 85-688

**85-686** (2)

**In The  
Supreme Court of the United States  
October Term, 1985**

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**GENERAL MOTORS CORPORATION AND  
METROPOLITAN LIFE INSURANCE COMPANY,**

**Petitioners,**

**-v.-**

**ARTHUR TAYLOR,**

**Respondent,**

---

**BRIEF IN OPPOSITION TO PETITIONS FOR A  
WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT**

---

**JAMES A. BRESCOLL  
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**QUESTION PRESENTED**

Did the Court of Appeals for the Sixth Circuit correctly hold that removal of an action alleging breach of contract, retaliatory discharge, and wrongful termination of disability benefits was improper, where the well-pleaded complaint did not raise a federal question, despite contentions that the Employee Retirement Income Security Act of 1974 converted plaintiff's state law claim for disability benefits into a claim under ERISA?

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No. 85-688

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In The  
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GENERAL MOTORS CORPORATION AND  
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**BRIEF IN OPPOSITION TO PETITIONS FOR A  
WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT**

---

**OPINIONS BELOW**

Respondent Arthur Taylor adopts the Petitioners recitation of opinions below.

---

## **JURISDICTION**

Respondent Arthur Taylor adopts the Petitioners recitation of jurisdiction below.

---

## **STATUTORY PROVISIONS INVOLVED**

This case involves:

28 U.S.C. § 1331 which provides: The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

28 U.S.C. § 1441 provides in pertinent part:

Section 1441. Actions removable generally

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a state court of which the district courts of the United States have original jurisdiction, may be removed by the defendant, or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State and in which such action is brought.

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## **STATEMENT OF THE CASE**

The Court of Appeals for the Sixth Circuit held that removal of an action alleging breach of contract, retaliatory discharge and wrongful termination of disability benefits was improper, where the well-pleaded complaint did not raise a federal question, despite contentions that the Employee Retirement Income Security Act of 1974 converted plaintiff's state law claim for disability benefits into a claim under ERISA.

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## **STATEMENT OF FACTS**

In 1951 Arthur Taylor began employment with General Motors Corporation (GM) as an hourly worker. While employed with GM, Taylor pursued his college education, and in June 1959 he became a salaried engineering analyst. Mr. Taylor received two raises by March 1960. In April 1961, Mr. Taylor was given a copy of the employee handbook "Working with General Motors" which included an "open door" policy.

On August 22, 1961, plaintiff was in Framingham, Massachusetts, to handle a quality control problem at the Chevrolet assembly plant there. While proceeding to the plant by car, Mr. Taylor was involved in an auto accident when he was rear-ended by a delivery truck travelling at 50 m.p.h. that was being pursued by the police. The plaintiff severely injured his neck and back in the accident which required treatment at the local hospital. When he returned home in two days, Mr. Taylor was treated by

Dr. George Curry of Flint for intense back, neck and leg pains. He was off work for two to three weeks and then returned to his job, but his supervisor told him to take another two weeks off of vacation.

When plaintiff finally returned to work his supervisor was displeased with him because of the accident. As a result, when plaintiff was appraised on October 10, 1961, the supervisor, August Slatinski, gave him a D3 rating which indicated unsatisfactory and not promotable.

Plaintiff had been receiving Blue-Cross/Blue-Shield benefits that paid for his medical expenses sustained as a result of the auto accident. When Blue-Cross found out that the bills were related to his on-the-job accident, it cut plaintiff off. Mr. Taylor then went to the Chevrolet Personnel Department to obtain a determination that his injuries were compensable, but Jim Lindsay refused it. Plaintiff consulted an attorney, James McDonald, who attempted to negotiate a settlement for him. Ultimately, McDonald filed a worker's compensation petition, but plaintiff stopped using him because Lindsay warned the plaintiff that he should not use an attorney. Ed Gray, Director of the Quality Control Department, went so far as to tell Mr. Taylor his job would be in jeopardy if he didn't drop his worker's compensation claim. When plaintiff could not resolve his problem in 1965, he finally utilized GM's "open door" policy and wrote Mr. Seaton, defendant's Director of Industrial Relations, to ask for help. With Mr. Seaton's help, the claim was finally resolved.

After this series of incidents, Mr. Taylor continued in his job duties which required considerable outside travel. He experienced problems in travelling due to his back and

neck condition but did not seek any medical restrictions for fear of reprisal by his superiors. During this time, plaintiff received numerous appraisals by his supervisors that were in the B1 and B2 range from 1966 through 1974. Plaintiff requested promotions and/or transfers to other divisions of GM during this period, but was consistently rebuffed in his attempts. In response to one such memo was the meeting between plaintiff and GM's personnel resulting in the memo to file of July 25, 1971, by B. L. Hilkené that stated in part:

Mr. Taylor was advised, however, that opportunities to place him were very limited based on the fact that his reputation as a dissatisfied employee would precede him.

...

It was emphasized during this meeting that neither Chevrolet nor General Motors' representatives intended to spend a career in handling his problems...

In order to resolve his difficulties, plaintiff again went to the "open door" policy to get out of the dead-end job he had with Chevrolet. In September 1977, Mr. Taylor was given a new edition of "Working with General Motors" which contained further "open door" policy promises.

In August 1978, Mr. Taylor was examined by Dr. Evanoff who placed him on medical travel restrictions for six months due to plaintiff's back and neck condition. Plaintiff went on sick leave for five and a half months and upon return GM took plaintiff off his job and placed him in a back room sampling area in a job involving no travel. The work given plaintiff was demeaning to him in that it was a clerical-type job at a 5th level where he filed forms, folders, print approvals and engineering notices. The job

did not appear to plaintiff to be created to accomodate his medical restrictions as the job involved bending, squatting and filing.

Between 1978 and May 1980, on numerous occasions, plaintiff requested that he be transferred to an area that could utilize his background, experience and education. These requests were pursued through the GM's "open door" policy. Plaintiff made these requests of Bob Johnson, his Group Supervisor of Quality Control, Mike Meyers, Assistant Manager of Quality Control, and Bruce Hilken, General Director of Personnel Chevrolet. Additionally, plaintiff requested a transfer to a warmer climate on April 17, 1980. He also requested promotions and/or transfers pursuant to GM's "open door" policy in employee pre-appraisal between 1977 and 1980. Again, he was not transferred to a 7th level job but was instead harassed by his supervisor, Pat Jones, who met with Mr. Taylor daily to criticize him.

The plaintiff was also going through a difficult divorce and child custody battle while he worked in the sampling area. He consulted with Dr. Yang, a licensed psychologist, for his psychological problems that he felt all stemmed from the retaliation that he received on the job. Finally, in May 1980 Dr. Yang advised Mr. Taylor that because of his mental state of mind, his sheer depression and his suicidal tendencies he should take a leave of absence.

Plaintiff notified defendant Metropolitan Life of his complete disability as a result of Dr. Yang's findings. Metropolitan Life paid sickness and accident benefits for over one month based upon Dr. Yang's report. At no time

during this period did Metropolitan Life notify Mr. Taylor that Dr. Yang's report was an insufficient proof of loss or illness. Thus, plaintiff, relying on defendant's payment of benefits, continued to treat with Dr. Yang.

In June of 1980 Metropolitan Life required Mr. Taylor to see Dr. Gordon Forrer for a psychiatric evaluation. At this time, plaintiff was interviewed for about 20 minutes wherein Dr. Forrer determined that Mr. Taylor was not psychiatrically able to return to work. Six weeks later plaintiff returned to Dr. Forrer's office where he was not even let in the door, was asked only two questions and was dismissed by the doctor in less than a minute. Dr. Forrer concluded, based upon this "evaluation", that plaintiff was fit to return to work.

In July 1980, Metropolitan Life sent plaintiff to the Detroit Industrial Clinic where he was examined by a Dr. Wilson. After a brief examination with no x-rays being taken, plaintiff was sent home. On July 24, 1980, plaintiff was cut off of his sickness and accident benefits by Metropolitan Life. This was extended until July 30, 1980, when plaintiff was cut off again. This necessitated Mr. Taylor filing a second worker's compensation claim with GM on August 6, 1980. Plaintiff remained off work based on Dr. Yang's advice and continued to receive no benefits from either defendant. Not until its Motion for Partial Summary Judgment did Metropolitan Life assert that the report of Dr. Yang was insufficient as proof of disability.

On November 5, 1980, plaintiff was required by GM to see Dr. Sokolowski at the Tech Center for a physical examination. The physician did not ask plaintiff about his psychological condition or ask for Dr. Yang's records.

Mr. Taylor returned the document to Jim Lindsay's office and went home. On November 10, 1980, plaintiff received a letter from Lendt informing him that his employment with GM had been terminated effective November 5, 1980. Plaintiff responded by letter that he hadn't been released by Dr. Yang, but GM did not respond to this. Since that date plaintiff has not found employment and has continued to treat with Dr. Yang.

Plaintiff asserts that he was not given promotions and ultimately terminated by GM in retaliation for filing his two worker's compensation claims and availing himself of defendant's so-called "open door" policy.

Arthur Taylor filed his Complaint on March 13, 1981, in the Circuit Court for the County of Wayne. On March 24, 1981, defendant GM, with the concurrence of Metropolitan Life Insurance Company, removed this action to Federal District Court for the Eastern District of Michigan. On May 4, 1981, the district court denied a motion to remand the case to state court.

On October 24, 1983, plaintiff filed his First Amended Complaint which consisted of three Counts. Count I alleged that GM failed to promote him over the years and terminated his employment in retaliation for his filing worker's compensation claims against the defendant. Count II of the Complaint alleged breach of insurance contract and sought disability insurance benefits against Metropolitan Life Insurance Company. Count III of the Complaint alleged that GM discharged plaintiff from employment in breach of his employment contract and further, that GM did not satisfy its contractual obligations under its "open door" policy.

Each of the defendants filed Motions for Summary Judgment which were granted by the Honorable Stewart Newblatt on May 17, 1984. On June 7, 1985, the Sixth Circuit Court of Appeals held that the action had been improperly removed to the federal district court and reversed the order of summary judgments with instructions that the case be transferred to the state court.

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## REASONS FOR DENYING PETITION

### I. The Sixth Circuit's Decision is in Conflict with Only the Tenth Circuit

The Sixth Circuit's holding in the present action that removal to federal district court on the basis of ERISA was improper in a claim for disability benefits is consistent with the Fifth Circuit's opinion in *Powers v. South Central United Food & Commercial Workers Unions and Employees Health & Welfare Trust*, 719 F.2d 760 (5th Cir. 1983).

Two decisions cited by General Motors Corporation to evidence a conflict between the Circuit Courts are not inconsistent with the Fifth or Sixth Circuit's decisions. In *Russell vs. Massachusetts Mutual Life Insurance Co.*, 722 F.2d 482 (9th Cir. 1983), reversed in 105 S.Ct. 3085 (1985), the Ninth Circuit held that the plaintiff's state law causes of action based upon the insurance carrier's handling of her disability claim were preempted by ERISA. *Id* at 485. The court, however, specifically noted in footnote 4 that:

Because no motion or other objection to removal was ever made by any party, we need not consider the question that would otherwise be presented pursuant to 28 U.S.C. § 1441. The rule governing an appellate court's inquiry subsequent to removal was stated by an unanimous Court in *Grubbs v. General Elec. Credit Corp.*, 405 U.S. 699, 702, 92 S.Ct. 1344, 1347, 31 L.Ed.2d 612 (1972); “. . . [w]here after removal a case is tried on the merits without objection and the federal court enters judgment, the issue in subsequent proceedings on appeals is not whether the case was properly removed, but whether the federal district court would have had original jurisdiction of the case had it been filed in that court.” While we acknowledge that *Grubbs* differs from the case before us because there the state court's original exercise of jurisdiction was proper, that distinction is not controlling; the principle announced by the Supreme Court in *Grubbs* applies regardless of whether the state court had jurisdiction over the matter when it was originally filed. The *Grubbs* rule has been specifically adopted by this circuit in cases where the merits are reached and determined on a motion for summary judgment. *Stone v. Stone*, 632 F.2d 740 (9th Cir.1980) (citing cases). See also *Lockwood Corp. v. Black*, 669 F.2d 324 (5th Cir. 1982). Because we hold *infra* that appellant stated a valid cause of action under ERISA the district court would have had original jurisdiction over appellant's claim had it originally been filed in that court.

Thus, any mention of removal jurisdiction in the *Russell* case was simply obiter dictum and is not an indication of a split in authority from this case.

Similiarly, the decision of *Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311, 1317 (5th Cir. 1985), held:

We are left with the unavoidable conclusion that state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to,

or coequal with any cause of action available under ERISA. See *Eversole v. Metropolitan Life Insurance Co.*, 500 F.Supp. 1162, 1170 (C.D.Cal.1980). Dedeaux's common law causes of action for Pilot Life's failure to pay disability benefits, therefore, are not preempted.

While this case is favorable to plaintiff in this action, the decision does not reach the issue of removability under ERISA to federal jurisdiction.

The only circuit court decision at odds with the Fifth and Sixth Circuit is *Roe v. General American Life Insurance Co.*, 712 F.2d 450, 452 (10th Cir. 1983), where the court held:

Recognizing that there is some split of authority, we believe that the insurance program of the sort here involved does come within the ambit of ERISA, and that the case was properly removed. The total plan is an “employee welfare benefit plan” within the meaning of 29 U.S.C. § 1003(1) . . .

At the federal district court level the plaintiff in *Roe* indicated that “he didn't really care whether his case was heard in federal or state court, but that they felt it his duty to advise the court that there was a split in authority as to whether an insurance program of the sort here involved [disability insurance] came within the ambit of ERISA”. 712 F.2d at 451. The *Roe* court further noted on 712 F.2d at 452, fn.\* that “[i]t would appear that jurisdiction could have also been based on diversity.” These facts contrast to the instant case where Mr. Taylor has asserted from the initial removal of his case to federal court that such an action was improper. Further, there is not complete diversity of citizenship in this case.

## II. This Case Does Not Involve Important Unresolved Federal Questions

As noted in this Court's decision in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 10 (1983):

For better or worse, under the present statutory scheme as it has existed since 1887, a defendant may not remove a case to federal court unless the plaintiff's complaint establishes that the case arises under "federal law. '[A] right or immunity created by the Constitution or laws of the United States must be an element, and an essential one of the plaintiff's cause of action' . . ." [citations and footnote omitted]

Thus, the Sixth Circuit was proper in relying on *Franchise Tax Board* and in denying removal to the federal court when the well-pleaded plaintiff's complaint asserted no claim under ERISA. This was proper based upon the resolved principal of the well-pleaded complaint rule. See also, *Gully v. First National Bank*, 299 U.S. 109 (1936) and *Great Northern Railway v. Alexander*, 246 U.S. 276 (1918). Any statement to the contrary in *Franchise Tax Board* is simply dictum.

## III. The Decision of the Sixth Circuit Court of Appeals was Proper

The Sixth Circuit Court of Appeals decision, which was based upon a long line of precedent under the well-pleaded complaint rule, was proper and should not be reversed. The court correctly stated in 763 F.2d at 219:

This case is not a case where the plaintiff has "'artfully' fail[ed] to plead essential federal issues in the complaint," *id.* (citing *Franchise Tax Board*, 103 S.Ct. at 2853), in order to avoid federal jurisdiction. Fur-

ther, we do not believe this is a situation where "the plaintiff's complaint clearly establishes that the claim is one necessarily rising under federal law," 719 F.2d at 766, justifying removal jurisdiction. It is not "clearly established" that actions for benefits allegedly due under a group insurance policy "necessarily" arise under federal law simply because the insurance policy is a part of an overall benefit plan established pursuant to ERISA.

The Fifth Circuit Court of Appeals in *Powers, supra*, further supports the proposition in stating at 719 F.2d 765:

Powers alleged no federal cause of action, raised no federal issue, and relied on no federal statute. Rather, she seeks relief based on the Texas DTPA, negligence, and fraud. ERISA's preemptive effect or the lack thereof arises solely on the basis of the Plan's pleadings and petition for removal. As an initial proposition, therefore, the "law that creates the cause of action" is state law, and original federal jurisdiction is lacking unless Powers' claim falls victim to an exception to the well-pleaded complaint rule.

As previously indicated, Mr. Taylor filed proper state claims in the present case. Thus, under the *Franchise Tax Board* rationale, the Sixth Circuit was correct in remanding the case back to where the plaintiff intended it to be brought, the state court in Michigan.

**CONCLUSION**

For the above reasons, the respondent, Arthur Taylor, requests that this Court deny the petitions for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit.

Respectfully submitted,

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# **JOINT APPENDIX**

5 6  
Nos. 85-686 and 85-688

Supreme Court, U.S.

FILED

MAY 2 1986

JOSEPH F. SPANIOLO, JR.  
CLERK

IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1985

GENERAL MOTORS CORPORATION and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioners,*

v.

ARTHUR TAYLOR,  
*Respondent.*

On Writs of Certiorari to the United States  
Court of Appeals for the Sixth Circuit

**JOINT APPENDIX**

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UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN

Docket Nos. 81-0939 and 81-4030

ARTHUR TAYLOR,

*Plaintiff*

v.

GENERAL MOTORS CORPORATION,  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants*

DOCKET ENTRIES

Date	Nr.	PROCEEDINGS
1981		
Mar. 24	1	Verified petition for removal from the Circuit Court for the County of Wayne, filed. DD 3/24/81
Mar. 24	2	Bond for removal in the sum of \$500.00, filed. DD 3/24/81
Mar. 24	3	Proof of service, filed. DD 3/24/81
Mar. 26	4	Order of disqualification & reassignment, from Judge Gilmore to Judge Joiner DD 3-27-81 Gilmore,
April 6	5	Plft's motion to remand, with notice of hearing on 4-14-81 at 2:00 p.m., brief & proof of service. DD 4-7-81
April 8	6	Stip. & order, re: that deft G.M.C. be allowed an additional 45 days to answer or otherwise respond to plft's complaint, such response is due on or before 5-22-81. DD 4-13-81 Joiner, J.

Date	Nr.	PROCEEDINGS
1981		
April 15	7	Memorandum of General Motors Corp. in opposition to plft's motion to remand, with certificate of service. DD 4-16-81
April 14	—	Motion to remand adj. to 4-21-81. DD 4-17-81
April 20	8	File from Wayne County Circuit Court. dd 4/21/81
April 21	9	Letter to the court from Mr. Hergt, re: adj. of trial to 4-28-81. DD 4-24-81
April 21	10	Memorandum of deft Metropolitan Life Insurance Co. in opposition to motion to remand with proof of service. DD 4-24-81
April 27	11	Plft's reply brief to defts' memoranda in opposition to plft's motion to remand, with proof of service. DD 4-28-81
April 28	12	Defendant G.M.'s response to motion to remand. DD 4/29/81.
April 29	13	Notice of status report to schedule discovery and etc. for June 24/81 at 2 pm. DD 4/30/81. Joiner, J.
April 28	—	Motion to remand, heard and denied. DD 5/1/81. Joiner, J.
April 21	—	Motion to remand adj. to 4/28/81. DD 5/4/81. Joiner, J.
May 4	14	Order denying plaintiff's motion to remand. DD 5/4/81. Joiner, J.
May 18	15	Answer of General Motors Corporation with affirmative defense and proof of service. DD 5/18/81.
June 3	16	Notice of adjournment and rescheduling of status report from June 24/81 to June 26/81 at 2pm. DD 6/3/81.

Date	Nr.	PROCEEDINGS
1981		
June 29	17	Order setting dates re: discovery cut-off 1/1/82; final pretrial order due 1/15/82; final pretrial conf. set for 2/1/82 at 2:00 pm and trial set for 2/15/82 at 8:30 am. DD 6/29/81 Joiner, J.
June 26	—	Pretrial conf. held. DD 7/1/81
July 14	18	Deft's answer to complaint with affirmative defenses and proof of service. dd 7/14/81.
Dec. 16	19	NOTICE of deposition of Arthur Taylor set for 12/23/81 at 9:30 am and request for production of documents. dd 12/17/81
Dec. 21	20	NOTICE of taking depositions of Stephen A. Evanoff, Dr. Andrew Young, and Dr. Newman on Dec. 21/ @ 10:00 A.M., with proof of service. DD 12/31/81
Dec. 28	21	PLTF'S motion to extend discovery cut-off date, final pre-trial order, final pre-trial conf. and trial date, with proof of service and notice of hearing without date. BA DD 12/31/81
Dec. 22	22	PROOF of service re: notice of deposition. DD 12/31/81
Dec. 30	23	ORDER of reassignment from Detroit to Flint. DD 1/4/82 Feikens, J.
Dec. 31	24	MOTION of Donnelly & Asso. to withdraw as counsel for pltf., with proof of service, brief and notice of hearing set for Jan. 27/82 ¶ 2:30 P.M. DD 1/4/82
1982		
Jan. 12		File received at Flint
Jan. 27	25	APPEARANCE & Notice of James A. Brescoll for pltf. w/proof ser. ddl-28-82

Date	Nr.	PROCEEDINGS
1982		
Jan. 29	26	CONSENT to substitution of counsel w/ notice of sub. dd2-2-82
Jan. 22	26A	APPEARANCE & Notice of appearance of James Brescoll for pltf. & proof ser. dd2-10-82
Feb. 10	27	ORDER consenting to substitution of counsel. Rubenstein, Pruchnicki, Chittle & Smith substituted in place of Dickinson, Wright, Moon, as atty. for deflt. Metropolitan Life Ins. Co. s/J. Newblatt 2-10-82. dd2-11-82/md
Feb. 18	28	CERTIFICATE of Service of Consent to & notice of substitution of counsel and order dd2/18/82
Mar. 4	29	NOTICE status conf set 4-13-82, 2:30 p.m. dd3-5-82
Mar. 21	30	SCHEDULING notice: disc cut off 11-1-82; final p/t 2-17-82, 3:00 p.m. TRIAL: 3-8-83, 8:30 a.m. w/proof ser dd4-23-82
May 13	31	NOTICE taking dep by pltf of Max Karl Newman, M.D., 6-12-82, 9:00 a.m. & Andrew T. Yang, Ph.D., 5-21-82, 2:00 p.m., w/proof ser dd5-13-82
May 13	32	NOTICE taking dep by pltf of Dr. Y.M. Alkar, 6-17-82, 2:00 p.m. w/proof ser dd5-13-82
May 17	33	NOTICE taking dep by pltf of Dr. Stephen A. Evanoff, 5-26-82, 3:00 p.m. w/proof ser. dd5-18-82
May 20	34	AMENDED notice taking dep by pltf of Max Karl Newman, M.D., 7-28-82 2:00 p.m. & Andrew T. Yank Ph.D, 5-28-82, 1:30 p.m. w/proof ser dd5-21-82
May 25	35	REQUEST by pltf for production documents dd5-26-82

Date	Nr.	PROCEEDINGS
1982		
May 25	36	INTERROG. by pltf to defts dd5-26-82
May 25	37	PROOF service #35, 36 dd5-26-82
June 14	38	AMENDED Notice taking dep by pltf of Andrew T. Yang, Ph.D 7-23-82, 9:30 a.m. w/proof mailing dd6-14-82
June 18	39	SUBSTITUTION of atty & consent to substitution: James Brescoll to appear for pltf. w/proof ser dd6-21-82
June 25	40	Pltf's Amended Notice of Taking Deposition re: Dr Y. M. Alkar on 7-20-82 @ 2:00 p.m. w/proof. dd 6-28
July 13	41	OBJECTION by Deft. Metropolitan to interrogatories by pltf dd/7/14
July 13	42	OBJECTION by Deft. Metropolitan to Pltf request for productions of documents except for request # 13 dd/7/14/82
July 13	43	PROOF of service of #42 & 43 objections dd/7/14/82
July 15	44	RE NOTICE of Taking Deposition of Stephen Evanoff w/proof of srv. dd/
July 23	45	MOTION pltf for disc., brief, afdt, proof ser dd7-26-82
July 28	46	ANSWER of deflt Metropolitan Life to pltf mot for dis. w/proof ser dd7-28-82
July 30	47	ANSWERS by deflt GMC to interrog w/proof ser dd8-3-82
Aug. 3	48	RESPONSE by deflt GMC to pltf request for prod doc. w/cert ser dd8-3-82
Aug. 10	49	DEPOSITION of Yasar Alkar, M.D. dd8-11-82

Date	Nr.	PROCEEDINGS
1982		
Aug. 16	50	DEPOSITION of Dr. Stephen A. Evanoff dd8-17-82
Aug. 31	51	MOTION of pltf for discovery with brief and proof of service dd/8/31
Sept. 3	52	DEPOSITION of Max Karl Newman, M.D. dd/9/3/82
Sept. 13	53	DEPOSITION of Dr. Stephen A. Evanoff dd9-14-82
Oct. 18	54	ORDER: parties to arrange conf. w/in 2 wks from date of order. w/proof. Judge Newblatt dd10-19
Oct. 25	55	NOTICE dep pltf of Ram Gunabalan MD, 10-26-82, 4:30, w/proof & Ram Gunabalan MD, 12-8-82, 2pm, w/proof dd10-26
Oct. 27	56	RE-NOTICE dep by pltf of Ram Gunabalan, 12-1-82, 4:30, proof dd10-29
Nov. 15	57	NTC taking dep by pltf of P.R. Lauber, MD, 12-7-82, 2pm, w/proof dd11-16
Dec. 22	58	NTC dep by pltf of P.R. Lauber, M.D., 1-6-83, 2pm, Dr. Robert C. Behan, 12-28-82, 2:45, proof ser dd12-22
Dec. 27	59	DEP of Ram Gunabalan, M.D. dd12-27
1983		
Jan. 4	60	ORDER: disc 3-1-83; final p/t 6-16-83; 3pm; trial 6-27-83, 8:30. w/proof. Judge Newblatt dd1-5-83
Jan. 5	61	LETTER (copy) by atty Davis to atty Moore re. documents in personal files of pltf. dd1-6
Jan. 6	62	DEP of Robert C. Behan, MD. dd1-12

Date	Nr.	PROCEEDINGS
1983		
Jan. 12	63	LETTER from Roy Moore, Atty for pltf. DEMAND for Jury trial in Wayne County Case —please renote as jury trial dd/1/12/83
Jan. 14	64	DEFT. GMC Supplemental answers to interrog. w/cert. of sr. dd/1/14/83
Feb. 7	65	MOT pltf for disc., brief, aff dd2-8
Feb. 7	66	SECOND request pltf for prod documents dd2-8
Feb. 7	67	PROOF ser 65, 66 dd2-8
Feb. 11	68	NTC dep by pltf on 2-25-83 of Michael Meyers, 9am, D.E. Harbold, 10am, Patrick Jones, 11am, W.F. Grundi, 1pm, R.G. Johnson 2pm, H.C. Detlefs 3pm, L.S. Rose 4pm, & on 2-28-83, M.E. Helmke, 1 pm, J. B. Keiffer, 2pm, R. Lendt, 4pm, B.L. Hilkenne, 4pm, proof dd2-14
Feb. 18	69	NTC dep by deft of pltf, 2-24-83, 9:30, w/proof dd2-22
Feb. 22	70	NTC dep by deft of pltf 2-24-83, 9:30, w/proof dd2-22
Feb. 24	71	NTC dep by pltf of James Lindsay, 3-1-83, 12pm, proof dd2-25
Mar. 1	72	MEMO in opposition to pltf mot for disc, cert ser dd3-1
Mar. 2	73	ORDER of reference to Mag. for disc. Judge Newblatt, w/proof dd3-3-83
Mar. 8	74	NTC hrg on disc mot before Mag. Carlson, 3-17-83, 9:30 dd3-9-83
Mar. 18	75	ORDER by Mag re. pltf mot disc: pltf mot disc GRANTED ONLY IN PART: deft GMC by 3-31-83 provide pltf w/ copies of independently prepared documents, excluding documents

Date	Nr.	PROCEEDINGS
1983		
		prepared by deft's counsel, which they may have pertaining to pltf 1961 auto accident & shall provide copies of all documents they have from pltf's personnel & medical files, including exam report of Dr. Reid, which they have produced, & shall submit an aff rep. they have so provided all such personnel or med. records known to be in their possession. Mag Carlson s/3-17-83 dd3-22-83
Mar. 28	76	NTC dep-duces tecum by pltf of James Lindsay, 4-14-83, 2pm, Michael Meyers & D.E. Harbold, 4-14-83, 3 & 4 pm, Patrick A. Jones, W.F. Grundy, R.G. Johnson, H.C. Detleff, L.S. Rose, M.E. Helmke, J.B. Keiffer, K.R. Lendt, B.L. Hilkenne, 4-15-83, starting at 9am, w/proof ser dd3-29-83
April 12	77	AMENDED ntc taking dep-duces tecum by pltf of R.C. LENDT, 4-27-83, 9:30 dd4-13-83
April 12	78	NTC dep-duces tecum by pltf of James Lindsay, 4-27-83, 10:30am, Dr. Sokolowski, 4-27-83, 1pm, Gordon R. Forrer, MD, 4-28-83, 2pm dd4-13-83
April 12	79	PROOF ser # 77, 78 dd4-13-83
April 21	80	MOT pltf to extend cut off & due dates for disc, p/t motions joint p/t statement, brief, aff. ntc hrg dd4-22-83
April 21	81	MOT pltf for default judgment, brief, aff, ntc hrg dd4-22-83
April 21	82	NTC dep by pltf of B.L. Hilkenne, 4-29-83, 10am & Richard J. Prunty, 4-29-83, 1pm dd4-22-83
April 21	83	PROOF ser # 80-82 dd4-22-83
April 29	84	NTC hrg on mot 5-18-83, 3pm dd5-2-83

Date	Nr.	PROCEEDINGS
1983		
May 6	85	NTC dep by pltf of Dr. Sokolowski, 5-20-83, 4pm, R.C. Lendt, 5-20-83 1pm, James Lindsay, 5-20-83, 2pm, B.L. Hilkenne, 5-23-83, 10am, Richard Prunty 5-23-83, 11am, Gordon Forrer, M.D. 5-24-83 8am, proof ser dd5-9-83
May 10	86	LETTER from atty Brescoll to law clerk re. aff indicating personnel records of GMC dd5-10-83
May 11	87	ORDER: Court will grant one more extension of dates/ but this time the dates must be taken seriously. Pltf is forewarned that further ext. will not be granted absent genuine emergency. Revised sched: disc cut off 9-1-83, joint p/t statement 11-3-83, final p/t 11-18-83, 3pm, trial 12-6-83, 8:30. w/proof. s/Judge Newblatt 5-11 dd5-11-83
May 12	88	COPY of aff of Margaret M. Fitzpatrick re. medical file w/cover letter dd5-12-83
May 17	89	LETTER from atty Davis to atty Brescoll re. deps set 5-4-83 & production documents. dd5-18-83
July 27	90	REQUEST pltf for production documents, proof
Aug. 9	91	NTC dep by deft of pltf 8-22-83, 1pm, w/proof
Aug. 11	92	NTC dep by deft of pltf., 8-22-83, 1pm w/proof
Aug. 26	93	RESPONSE of GMC to req. for prod. of doc. w/cert. of srv.
Sept. 1	94	MOT to amend complaint, brief, proof ser
Sept. 1	95	MOT pltf to compel production documents, brief, proof ser
Sept. 1	96	AFF atty for pltf re. 94, 95

Date	Nr.	PROCEEDINGS
1983		
Sept. 1	97	NTC hrg by pltf re. 94, 95
Sept. 8	98	ORDER Requiring implementation Local Rule 17a2. Judge Newblatt 9-8
Sept. 14	99	MEMO of deft GMC in opposition to pltf mot amend complaint, attachments, proof ser
Sept. 21	100	NTC dep by deft of pltf 9-23-83, 1pm w/proof ser
Sept. 26	101	STIP regarding pltf's mot compel production documents, proof
Oct. 5	102	NTC dep by pltf of pltf 10-26-83, 1 pm, w/proof
Oct. 6	103	SUPPLEMENTAL Memo of deft GMC in opposition to pltf mot to amend. attachments, cert ser, w/ cover letter.
Oct. 6	104	DEP of Arthur Taylor
Oct. 11	105	OBJ by pltf to supplemental memo submitted by deft GMC in opposition to pltf mot amend, proof
Oct. 11	106	ORDER compelling prod documents to deft GMC. Judge Newblatt 10-10-83 w/proof
Oct. 11	107	ORDER: Court will grant pltf mot amend. Judge Newblatt 10-10-83 w/proof ser
Oct. 24	108	FIRST AMENDED COMPLAINT, jury demand, proof ser
Oct. 24	109	ANSWER of GMC to first amend complaint, proof ser & affirm def
Oct. 26	110	REPLY by pltf to affirm defense, proof
Oct. 31	111	COPIES Of letters forwarded by counsel to Judge Newblatt
Nov. 1	112	ANSWERS & affirm def to 1st amend complaint by deft Metropolitan

Date	Nr.	PROCEEDINGS
1983		
Nov. 1	113	MOT deft Metro. for partial sj as to pltf claim for compensatory, exemplary &/or punitive damages, aff, proof
Nov. 1	114	PROOF ser of answers to 1st amend complaint
Nov. 2	114A	ADD. aff of Metro in support mot partial sj, proof
Nov. 3	115	ORDER: mot deft Metro for partial sj set for hrg 11-18-83, 3pm Judge Newblatt 11-3-83 w/proof mail
Nov. 16	116	MOT deft Metropolitan for partial sj as to pltf claim for disability benefits resulting from alleged psych. condition, brief, aff, ntc hrg
Nov. 16	117	MOT deft Metropolitan for separate trial, aff, brief, ntc hrg
Nov. 22	118	ORDER: dft. Metropolitan's motion to dismiss is granted, counsel to meet on 11/22/83 at 2pm to draft pretrial statement, final pretrial set for 11/25/83 at 3pm. NewBlatt, J. cdo
Nov. 28	119	MOT deft Metropolitan for partial sj as to pltf claim for disability benefits resulting from alleged back condition, brief, proof ser
Dec. 7	120	NTC trial set 2-13-84, 8:30 JT
Dec. 7	121	ANSWER by pltf to deft mot partial sj as to pltf claim for disability benefits resulting from alleged "back" condition, brief.
Dec. 7	122	ANSWER by pltf to deft Metro. mot partial sj as to pltf claim for disability from alleged psychological condition, brief
Dec. 7	123	ANSWER by pltf to deft Metro. mot separate trial, brief

Date	Nr.	PROCEEDINGS
1983		
Dec. 8	124	ORDER: deft Metro. mot sj & mot separate trial DENIED; pltf granted 2 weeks from date of hrg to file joint p/t statement, w/proof ser. s/Judge Newblatt 12-8-83
Dec. 14	125	STIP/ORDER re protective order. s/Judge Newblatt 12-13-83
Dec. 20	126	JOINT p/t statement
Dec. 22	127	MOT deft GM for sj, brief, aff Margaret Fitzpatrick, exhibits
Dec. 22	128	NTC of supplement by deft Metro. to joint p/t statemnt, proof ser
Dec. 23	129	NTC by deft Metropolitan of 2nd supp. to joint p/t statement, proof
Dec. 27	130	AFF of Margaret Fitzpatrick w/cover letter
Dec. 29	131	OBJ by pltf to deft Metro ntc of supp. to joint p/t statement, proof
Dec. 30	132	MOT pltf to extend date of answering deft GMC mot sj, brief, aff, ntc hrg, proof ser
1984		
Jan. 5	133	ORDER: dft GMC's motion for summary judgment filed 12/22/83 set for hearing on 1/25/84 @ 3:00, w/Proof of Mailing. Newblatt, J.
Jan. 6	134	ORDER granting mot. to ext. time to respond to mot. for sum. jgmnt. Plaintiff has until 1/16/84 to serve response s/Judge Newblatt 1/6/84 w/proof of mailing
Jan. 9	135	OBJ by pltf to deft Metro. second add. list of exhibits, proof ser

Date	Nr.	PROCEEDINGS
1984		
Jan. 11	136	SECOND MOT of deft Metro. for partial sj as to pltf claim for disability benefits resulting from alleged psych. condition, brief, ntc hrg, proposed order, attachments.
Jan. 11	137	REPLY brief & supp brief in support of deft Metro mot for partial sj dismissing pltf claim for disability benefits resulting from alleged "back" condition, attachment
Jan. 11	138	SECOND mot for deft Metro for separate trial, brief, aff, ntc hrg, proposed order
Jan. 11	139	AFF of Richard J. Prunty, w/attachments.
Jan. 11	140	PROOF ser 136-139
Jan. 16	141	RESPONSE by pltf to deft GMC mot sj, proof ser
Jan. 16	142	BRIEF pltf in response to deft mot sj
Jan. 16	143	AFF pltf
Jan. 19	144	ANSWER by pltf to deft Metro. 2nd mot for separate trial, brief, proof
Jan. 19	145	ANSWER by pltf to deft Metro. 2nd mot partial sj as to pltf claim for disability benefits resulting from alleged psych. condition, brief, proof
Jan. 20	146	MEMO of deft GMC in reply to pltf, cert ser
Jan. 16	147	REPLY brief of Metro. Ins in support its 2nd mot partial sj as to pltf claim for disability resulting from alleged psych. condition w/cert. ser
April 14	148	NTC trial 5-29-84, 8:30
April 23	149	MEMO/Opinion order: Metropolitan's two mot. partial sj GRANTED; GM's motions for sj GRANTED; and this case DISMISSED. W/PROOF SER Judge Newblatt 5-17-84

Date	Nr.	PROCEEDINGS
1984		
April 23	150	JUDGMENT (Clerk's): It is ordered & adj that pla take nothing & action. dism. s/5-23-84
April 31	150A	MOT pla for reconsideration of sj, brief, aff, ntc hrg, proof sr
June 1	151	PROOF ser by pla of mot reconsideration
June 1	152	ORDER: Memo Opin/order of 5-17-84 is hereby amended at top of page 2 to reflect that this case was removed from Wayne County Circuit Court because it arose under ERISA of 1974, 29 USC § 1132a. Further, Court by Judge Joiner, denied pla mot remand on 5-4-81. w/ proof mail Judge Newblatt 6-1-84
June 11	153	RESPONSE by dft to pla mot reconsideration filed 6-1-84.
June 11	154	AMEND by pltf to mot for reconsideration of sj, brief
June 19	155	RESPONSE BY DFT TO PLA AMEND to mot for reconsideration (letter form)
June 22	156	ACKNOWLEDGEMENT of receipt by dft Metro. to pla mot reconsideration. (letter form)
July 3	157	ORDER: pla mot for reconsideration DENIED. w/proof mail. s/Judge Newblatt 7-3-84
July 17	158	NOTICE OF APPEAL from Order of 7/3/84 filed by plft. With cover letter stating no transcript will be ordered Rec #094769 w/proof of mailing to: 6th Circuit Court of Appeals with cc of dkt, #157,150,149,152 David M. Davis, Rubenstein, Pruchnicki et al, Deane Williams Mr. Brescoll forwarded appeal instructions and forms with copy of docket

UNITED STATES COURT OF APPEALS  
FOR THE SIXTH CIRCUIT

Case No. 84-1503

ARTHUR TAYLOR,  
*Plaintiff-Appellant,*

vs.

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants-Appellees.*

DOCKET ENTRIES

Date	Nr.	FILINGS-PROCEEDINGS
1984		
7/20	1)	Copy of notice of appeal filed; and cause docketed rk
7/20	2)	Pre-argument statement filed rk
7/27	3)	Appearance of D. Davis for appellee pje
7/27	4)	Corporate Disclosure of appellee pje
7/30	5)	Appearance of J. Brescoll for appellant pje
7/30	6)	Corporate Disclosure of appellant pje
8/01	7)	Notice from counsel that transcript is unnecessary rk
8/02	8)	Appearance of G. Rubenstein for appellee (Metropolitan Life Ins.) pje

Date	Nr.	FILINGS-PROCEEDINGS
1984		
8/02	9)	Corporate Disclosure of appellee (Metropolitan Life Ins.) pje
8/07		<i>Certified Record</i> (3 vol. pleadings, 7 vol. depositions) filed; briefing started rk
8/16		<i>Certified Supplemental Record</i> (1 vol. pleadings) filed jk
9/17		Brief (10 of appellant (m-9/14/84) lb
10/12		Brief (10) of appellee (m-10/11/84) (MLI) lb
10/15		Brief (10) of appellee (m-10/10/84) (GM) TENDERED Filed 10/25/84 lb
10/15	10)	Motion: appellee (GM) to allow [52]page brief (m-10/10/84) (Motion granted; JPH/jt 10/25) lb
10/29		Reply Brief (10) of appellant (m-10/25/84) lb
10/30	11)	Motion: appellant to 11/21/84 to file joint appendix (m-10/26/84) (Extension to 11/21 granted; JPH/jk 10/30) lb
11/05	12)	Motion: appellee to strike the 2nd legal argument in reply brief (m-11/2/84) lb
11/19	13)	Response: appellant to appellee motion to strike 2nd legal argument in reply brief (m-11/16/84) lb
11/19	14)	Motion: appellant 2nd extension to 12/12/84 to file joint appendix (m-11/14/84) (Motion granted; JPH/jt 11/29) lb
11/23	15)	Response: appellee to appellant reply to motion to strike 2nd argument (m-11/21/84) lb
11/29		<i>Certified Supplemental Record</i> , ( 1 vol. of pleadings, 2 vol. of dep.) mdm
12/03		Joint Appendix (5) (m-11/29/84) lb

Date	Nr.	FILINGS-PROCEEDINGS
1985		
1/21	16)	ORDER: denying motion to strike appellant's second legal argument set forth in reply brief; further ordered that appellees may file response to second legal argument of no more than 5 pages and submitted to the court by 2/4/85 (Engel, tb
2/06	17)	MOTION/APPELLEE: extension, 7 days to file response brief of #16 (m-2/4) (Extension to 2/12 granted; JPH/jt 2/8) lb
2/08		RESPONSE BRIEF/APPELLEE: (10) (m-2/6) lb
3/13	18)	CITATIONS: updating brief of appellee Metropolitan Life Ins. (m-3/11) ert
3/18	19)	CITATIONS: updating brief of appellee General Motors (m-3/18) ert
4/08		CAUSE ARGUED by Dennis P. Brescoll for appellant, by David M. Davis and Gilbert Y. Rubenstein for appellee (Before: Wellford, Milburn and Kinneary, JJ.) tb
4/18	20)	ADDITIONAL CITATIONS: of appellee (m-4/15) jk
6/07	21)	JUDGMENT: reversed and remanded with instructions to transfer case to state court (Wellford, Milburn and Kinneary, JJ.) (Appellees to recover costs)
6/07		OPINION, Wellford, J.
6/20	22)	PETITION FOR REHEARING or in the alternative PETITION FOR REHEARING ENBANC filed by appellee (m-6/19) ert
7/03	23)	SUPPLEMENT/APPELLEE: in Support of Petition for Rehearing (m-7/2) ert

Date	Nr.	FILINGS-PROCEEDINGS
1985		
7/25	24)	ORDER: denying petition for rehearing en banc (Wellford, J.) tb
8/05	25)	MANDATE, issued (No costs taxed) tb
8/16	26)	MOTION/APPELLANT: for clarification of judgment regarding award of costs (with Brief in Support) (m-8/13) ert
8/22	27)	RESPONSE/APPELLEE: to Motion for Clarification (m-8/21) ert
8/23	28)	RESPONSE/APPELLEE [Metro. Life]: to appellant's motion for clarification (m-8/21) ert
9/13	29)	ORDER: permitting appellant to recover costs on appeal; district court instructed not to award appellant costs for improvident removal (Wellford, J.) tb
9/85		Certified copy of above order sent to district court tb
11/06	30)	SUPREME COURT NOTICE: petition for cert. filed 10/23/85 by General Motors (Sup. Ct. No. 85-688) tb
11/06	31)	SUPREME COURT NOTICE: petition for cert. filed 10/22/85 by Metropolitan Life (Sup. Ct. No. 85-686) tb
1986		
3/04	32)	SUPREME COURT ORDER: cert. granted; consolidated with 84-1502 teb
3/04		SERVICE of Supreme Ct. ruling to Dist. Ct. teb

STATE OF MICHIGAN  
IN THE CIRCUIT COURT  
FOR THE COUNTY OF WAYNE

81-110499 CK

ARTHUR TAYLOR,  
*Plaintiff,*

—VS—

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

COMPLAINT

NOW COMES Plaintiff, ARTHUR TAYLOR, by and through his attorneys, DONNELLY & ASSOCIATES, P.C., and for his complaint against Defendants, GENERAL MOTORS AND METROPOLITAN LIFE INSURANCE COMPANY, alleges as follows:

COUNT I

1. That Plaintiff is a resident of the City of Flint, County of Genessee, State of Michigan.

2. That General Motors is a Delaware Corporation with its principal place of business in Michigan and Metropolitan Life Insurance Company is a New York Corporation licensed to do business in Michigan.

3. That the amount in controversy exceeds Ten Thousand (\$10,000.00) Dollars or is otherwise within the jurisdiction of the Court.

4. That on or about July of 1955, Plaintiff accepted General Motor's offer of employment and agreed to furnish his services as an engineer in General Motors Corporation.

5. That in August of 1961, Plaintiff was involved in an automobile accident which occurred in the course of Plaintiff's employment with General Motors Corporation.

6. That as a direct and proximate result of said accident, Plaintiff suffered injuries to his back, neck, head and legs.

7. That despite the treatment and medical attention Plaintiff received immediately after the accident, Plaintiff has been hospitalized on numerous occasions since the date of the accident, has been treated and examined by numerous doctors and specialists, and has made every reasonable effort to correct his back and neck problem.

8. That Plaintiff has been diagnosed as having degenerative osteo-arthritis of the cervical and lumbosacral spine, a permanent medical impairment which limits Plaintiff's walking, standing, climbing, etc. . .

9. That Plaintiff's doctors, supported by numerous consulting specialists, have pronounced Plaintiff totally disabled from returning to normal and customary work duties with General Motors Corporation.

10. That prior to Plaintiff's condition becoming totally disabling, his doctors placed travel restrictions on Plaintiff and also recommended that he move to a warm, dry climate for therapeutic trial to live for at least six months.

11. That each and every work restriction placed on Plaintiff from a medical standpoint was met with greater resistance and harassment from departmental management at General Motors, i.e., after Plaintiff's doctors recommended a transfer to a warm, dry climate, manage-

ment at General Motors attempted to transfer Plaintiff to a cold, damp warehouse.

12. That Plaintiff has filed a Worker's Compensation claim with General Motors, and submitted to medical examination by General Motors' Doctors.

13. That after brief and superficial examination by General Motors' doctors, they concluded Plaintiff's medical condition had improved to the level where Plaintiff could again report to work, despite extensive medical documentation and evidence to the contrary.

14. That Plaintiff was terminated from his position with General Motors on November 5, 1980, allegedly for failing to report back to work as ordered by General Motors.

15. That the actual reason for Plaintiff's discharge was two-fold: (a) Plaintiff's serious medical condition required medical restrictions to be placed on him, restrictions which General Motors objected to; (b) Plaintiff filed a worker's compensation claim for his total disability with General Motors, and General Motors' firing of the Plaintiff was in retaliation for filing said claim.

16. That General Motors' discharge of Plaintiff because of medical restrictions placed on him and in retaliation for filing a worker's compensation case are against the public policy of this state.

17. That because of General Motors' retaliatory discharge, Plaintiff has been greatly damaged in that he lost pay compensation, all benefits and insurance coverages, and has suffered loss of esteem among family and friends, and humiliation, all to his great detriment.

WHEREFORE, Plaintiff prays for a judgment that is both fair and equitable, including compensatory and exemplary damages in excess of Ten Thousand (\$10,000.00) Dollars and interest thereon, plus costs and attorney fees.

## COUNT II

For Count II of his Complaint, Plaintiff alleges as follows:

18. That Plaintiff hereby adopts and incorporates by reference, each and every allegation contained in paragraphs one (1) through seventeen (17) of Count I herein as paragraph eighteen of Count II.

19. That pursuant to Plaintiff's employment agreement with General Motors, General Motors agreed to provide certain benefits and insurance coverages to Plaintiff.

20. That the premium for said benefits and insurance policies were paid by General Motors for Plaintiff's benefit.

21. That the following were provided through the Metropolitan Life Insurance Company to Plaintiff:

- (a) Basic Group Life Insurance and Extra Accident Insurance (Group Policy No. 14000-G)
- (b) Survivor Income Benefit Insurance (Group Policy No. 22500-G)
- (c) Sickness and Accident Insurance and Extended Disability Benefit Insurance (Group Policy No. 18501-G)

22. That said Sickness and Accident Insurance Policy, effective date 1977, provides that in the event of total disability and the inability to work certain monthly benefits were to be paid.

23. That the 1980 General Motors personnel benefit summary stated that in the event of total disability, Plaintiff was entitled to receive salary continuation and/or disability benefits of Two Thousand Four Hundred and Sixty-Two (\$2,462.00) Dollars per month for twenty-

six (26) weeks and One Thousand Eight Hundred and Thirteen (\$1,813.00) Dollars per month for the next twenty-seven (27) weeks.

24. That on July 30, 1980, when said Sickness and Accident Insurance Policy was in full force and when Plaintiff was totally disabled and dependant on said monthly benefits for his entire income, Metropolitan Life Insurance Company wrongfully and maliciously discontinued said insurance coverage in breach of the insurance contract.

25. That due notice of Plaintiff's disability was given to the insurer, Metropolitan Life, and Plaintiff has duly performed all the conditions of said policy on his part.

26. That the termination of disability payments has caused Plaintiff great financial hardship and left Plaintiff unable to adequately provide for or support himself and his two minor sons, for whom Plaintiff is sole legal guardian.

27. That as a result of the improper discontinuance of said benefits, Plaintiff has suffered great mental anguish due to the real and distinct possibility that Plaintiff will lose custody of his two sons.

28. That this is a real possibility because Plaintiff lacks the means to adequately support them and provide for their basic human and medical needs.

29. That Plaintiff's back condition prevents him from gaining other meaningful employment.

WHEREFORE, Plaintiff prays for a judgment that is both fair and equitable, said judgment consisting of compensatory damages for money contractually owed Plaintiff, compensation for mental anguish caused by breach of this contract, as well as immediate reimplementation of all benefits and insurance coverages Plaintiff is en-

titled to, together with interest thereon, costs and attorney fees.

Respectfully submitted,

By: /s/ \_\_\_\_\_  
 V. PAUL DONNELLY (P 12879)  
 Attorney for Plaintiff  
 2066 City National Bank Bldg.  
 Detroit, Michigan 48226  
 (313 963-4200)

UNITED STATES DISTRICT COURT  
 EASTERN DISTRICT OF MICHIGAN  
 SOUTHERN DIVISION

\_\_\_\_\_  
 No. 81-70939

Hon. Charles W. Joiner

ARTHUR TAYLOR,

*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, a foreign corporation,  
 and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

\_\_\_\_\_  
 ANSWER OF GENERAL MOTORS CORPORATION

\_\_\_\_\_  
 CERTIFICATE OF SERVICE

\_\_\_\_\_  
 DAVID M. DAVIS (P24006)  
 General Motors Corporation  
 Attorney for Defendant  
 3044 West Grand Boulevard  
 Detroit, Michigan 48202  
 Telephone: (313) 556-4096

OTIS M. SMITH  
 General Counsel

M. J. Basford  
 E. J. Dilworth, Jr.  
 J. R. Wheatley  
 Of Counsel

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

No. 81-70939

Hon. Charles W. Joiner

ARTHUR TAYLOR,  
*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a for-  
eign corporation, jointly and severally,  
*Defendants.*

ANSWER OF GENERAL MOTORS CORPORATION

NOW COMES Defendant, General Motors Corporation,  
by and through its attorney, David M. Davis, and in an-  
swer to the Complaint filed herein says as follows:

COUNT I

1. This Defendant does not have knowledge sufficient  
to form a belief as to the truth or falsity of the allega-  
tions of Count I, Paragraph 1 of the Complaint and  
leaves Plaintiff to his proofs.

2. This Defendant admits that it is a corporation ex-  
isting under the laws of the State of Delaware and is  
licensed to do and is doing business in the State of Michi-  
gan. All other allegations of Count I, Paragraph 2 are  
denied.

3. The allegations of Count I, Paragraph 3 are hereby  
denied and Plaintiff is left to his proofs.

4. The allegations of Count I, Paragraph 4 are hereby  
denied. Defendant admits only that Plaintiff commenced  
employment at Fisher Body, Willow Run, on June 25,  
1959. Thereafter he was transferred to Chevrolet Motor  
Division on October 10, 1961. Additionally, Plaintiff has  
had prior service with General Motors Corporation at  
Buick Motor Division from February, 1951 to September,  
1951 and at A.C. Spark Plug from April, 1953 to Au-  
gust, 1958.

5. This Defendant admits only that Plaintiff was in-  
volved in an automobile accident in 1961 which occurred  
in the course of Plaintiff's employment with General  
Motors Corporation. All other allegations of Count I,  
Paragraph 5 are denied and Plaintiff is left to his proofs.

6. The allegations of Count I, Paragraph 6 are hereby  
denied and Plaintiff is left to his proofs.

7. This Defendant does not have knowledge sufficient  
to form a belief as to the truth or falsity of the allega-  
tions of Count I, Paragraph 7 and therefore leaves Plain-  
tiff to his proofs.

8. This Defendant does not have knowledge sufficient  
to form a belief as to the truth or falsity of the allega-  
tions of Count I, Paragraph 8 and therefore leaves Plain-  
tiff to his proofs.

9. This Defendant does not have knowledge sufficient  
to form a belief as to the truth or falsity of the allega-  
tions of Count I, Paragraph 9 and therefore leaves Plain-  
tiff to his proofs.

10. This Defendant does not have knowledge sufficient  
to form a belief as to the truth or falsity of the allega-  
tions of Count I, Paragraph 10 and therefore leaves  
Plaintiff to his proofs.

11. The allegations of Count I, Paragraph 11 are here-  
by denied and Plaintiff is left to his proofs.

12. This Defendant admits only that Plaintiff has filed a worker's compensation claim with the Department of Labor, State of Michigan. All other allegations of Count I, Paragraph 12 are denied and Plaintiff is left to his proofs.

13. The allegations of Count I, Paragraph 13 are hereby denied and Plaintiff is left to his proofs.

14. This Defendant admits only that Plaintiff was examined by the Plant Medical Director on November 5, 1980 and found able to return to restricted work. Further, Plaintiff was so advised and his failure to report to work on November 10, 1980 resulted in his release from employment effective November 5, 1980. All other allegations of Count I, Paragraph 14 are hereby denied and Plaintiff is left to his proofs.

15. The allegations of Count I, Paragraph 15 are hereby denied and Plaintiff is left to his proofs.

16. The allegations of Count I, Paragraph 16 are hereby denied and Plaintiff is left to his proofs.

17. The allegations of Count I, Paragraph 17 are hereby denied and Plaintiff is left to his proofs.

WHEREFORE, Defendant General Motors Corporation prays that Plaintiff's Complaint filed herein be dismissed and that Plaintiff take nothing by reason of such Complaint and further that said Defendant be awarded its costs and reasonable attorneys fees.

## COUNT II

18. Defendant General Motors Corporation hereby adopts and incorporates by reference each and every response to Count I, Paragraphs 1-17, of Plaintiff's Complaint as if such responses were set out in full herein.

19. The allegations of Count II, Paragraph 19 are hereby denied and plaintiff is left to his proofs.

20. The allegations of Count II, Paragraph 20 are hereby denied and Plaintiff is left to his proofs.

21. This Defendant makes no response to this Paragraph but rather refers to the terms and conditions of the group policies identified in Count II, Paragraph 21 of the Complaint.

22. This Defendant refers specifically to the terms and conditions governing sickness and accident benefits. All allegations of Count II, Paragraph 22 are denied.

23. This Defendant refers specifically to the 1980 General Motors Personal Benefit Summary. All allegations of Count II, Paragraph 23 are hereby denied and Plaintiff is left to his proofs.

24. Defendant General Motors Corporation makes no response to Count II, Paragraph 24 because said paragraph is directed against Defendant Metropolitan Life Insurance Company.

25. Defendant General Motors Corporation makes no response to Count II, Paragraph 25 of the Complaint because said paragraph is directed against Metropolitan Life Insurance Company.

26. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count II, Paragraph 26 and therefore leave Plaintiff to his proofs.

27. The allegations of Count II, Paragraph 27 of the Complaint are denied and Plaintiff is left to his proofs.

28. The allegations of Count II, Paragraph 28 are hereby denied and Plaintiff is left to his proofs.

29. The allegations of Count II, Paragraph 29 are hereby denied and Plaintiff is left to his proofs.

WHEREFORE, Defendant General Motors Corporation prays that Plaintiff's Complaint be dismissed, that Plain-

tiff take nothing by his Complaint and that this Defendant be awarded its costs and attorneys fees in defending this matter.

### AFFIRMATIVE DEFENSES

1. Plaintiff has failed to state a claim.
2. Plaintiff has failed to state a claim upon which relief can be granted.
3. Plaintiff's action cannot be maintained in this Court because it is within the exclusive jurisdiction of the Bureau of Worker's Disability Compensation, Department of Labor, State of Michigan.
4. Plaintiff may not maintain this action against this Defendant because such action is barred by the applicable statute of limitations.

Respectfully submitted,

By /s/ David M. Davis  
 DAVID M. DAVIS (P24006)  
 Attorney for Defendant  
 General Motors Corporation  
 3044 West Grand Boulevard  
 Detroit, Michigan 48202  
 Telephone: (313) 556-4096

OTIS M. SMITH  
 General Counsel

M. J. Basford  
 E. J. Dilworth, Jr.  
 J. R. Wheatley  
 Of Counsel

### UNITED STATES DISTRICT COURT EASTERN DISTRICT OF MICHIGAN SOUTHERN DIVISION

No. 81-70939

Hon. Charles W. Joiner

ARTHUR TAYLOR,

v. *Plaintiff,*

GENERAL MOTORS CORPORATION, a foreign corporation,  
 and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

### CERTIFICATE OF SERVICE

STATE OF MICHIGAN )  
 ) ss.  
 COUNTY OF WAYNE )

I, Barbara K. Hampson, hereby certify that on the 15th day of May, 1981, I served a copy of the Answer of General Motors Corporation in the above-captioned matter, by depositing same in a U.S. mail receptacle with postage fully prepaid thereon, upon:

V. Paul Donnelly, Esq.  
 2066 City National Bank Building  
 Detroit, Michigan 48226

/s/ Barbara K. Hampson  
 BARBARA K. HAMPSON

Subscribed and sworn to before me this 15th day of May, 1981.

/s/ Marilyn G. deRaad  
 MARILYN G. DERAAD  
 Notary Public,  
 Macomb County, Mich.  
 Acting in Wayne  
 County, Mich.  
 My Commission Expires  
 February 9, 1985

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

Civil Action No. 81-70939

Hon. Charles W. Joiner

ARTHUR TAYLOR,  
—vs— *Plaintiff,*

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

ANSWER

NOW COMES Defendant, Metropolitan Life Insurance Company, by and through its attorneys, Dickinson, Wright, McKean, Cudlip & Moon, and for its Answer to the Complaint of Plaintiff, heretofore filed, states as follows:

1. Defendant neither admits nor denies the allegations of Paragraph 1, being without sufficient knowledge or information to form a belief as to the truth thereof.
2. Defendant admits the allegations of Paragraph 2.
3. Answering Paragraph 3, Defendant admits only that Plaintiff alleges that there is an amount in controversy in excess of \$10,000 and neither admits nor denies all other allegations or inferences of Paragraph 3.
- 4-17. Defendant neither admits nor denies the allegations of Paragraphs 4 through 17 of Plaintiff's Complaint, being without sufficient knowledge or information to form a belief as to the truth thereof.

18. Defendant incorporates herein by reference its Answers to Paragraphs 1 through 17 of Plaintiff's Complaint, and realleges the same as if fully set forth herein.

19. Defendant neither admits nor denies the allegations of Paragraph 19, being without sufficient knowledge or information to form a belief as to the truth thereof.

20. Defendant neither admits nor denies the allegations of Paragraph 20, being without sufficient knowledge or information to form a belief as to the truth thereof and for the further reason that the same constitute conclusions of law.

21. Answering Paragraph 21, Defendant admits only that Metropolitan Life Insurance Company previously issued to General Motors Corporation the group policies of insurance referred to in Paragraph 21, and that said group policies of insurance insured eligible and participating employees of General Motors Corporation during the period of their employment and pursuant to the terms and conditions of such insurance policy contracts. Defendant further admits that Plaintiff was insured under the aforesaid group policies of insurance only to the extent that he was an eligible and participating employee of General Motors Corporation and met the terms and conditions of said policies of insurance, and only during the period of his employment with General Motors Corporation. Defendant denies as untrue all other allegations or inferences of Paragraph 21.

22. Defendant denies the allegations of Paragraph 22 in the manner and form alleged, and avers that its Group Policy of Insurance No. 18501-G is a written document which speaks for itself as to its terms.

23. Defendant neither admits nor denies the allegations of Paragraph 23, being without sufficient knowledge or information to form a belief as to the truth thereof.

24. Defendant denies as untrue the allegations of Paragraph 24.

25. Defendant denies as untrue the allegations of Paragraph 25.

26. Defendant neither admits nor denies the allegations of Paragraph 26, being without sufficient knowledge or information to form a belief as to the truth thereof.

27. Defendant denies as untrue the allegations of Paragraph 27.

28. Defendant neither admits nor denies the allegations of Paragraph 28, being without sufficient knowledge or information to form a belief as to the truth thereof.

29. Defendant neither admits nor denies the allegations of Paragraph 29, being without sufficient knowledge or information to form a belief as to the truth thereof.

#### *AFFIRMATIVE DEFENSES*

1. Plaintiff's Complaint fails to state a claim, in whole or in part, upon which relief may be granted.

2. Plaintiff's Complaint fails to state a claim upon which relief may be granted in part because Plaintiff may not recover extra-contractual damages for breach of an insurance contract.

3. Plaintiff has failed to meet the conditions precedent to recovery under the policies of insurance referred to in Plaintiff's Complaint.

4. Defendant reserves the right to file such other and further affirmative defenses as discovery shall hereafter show to be applicable.

WHEREFORE, Defendant Metropolitan Life Insurance Company respectfully requests a judgment of no

cause against Plaintiff and in favor of Defendant, together with costs and attorneys' fees.

DICKINSON, WRIGHT,  
MCKEAN, CUDLIP &  
MOON

By: /s/ Philip M. Frost  
PHILP M. FROST (P24015)  
800 First National Building  
Detroit, Michigan 48226  
313-223-3500

Dated: July 14, 1981

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

Civil Action No. 81-70939

HON. CHARLES W. JOINER

ARTHUR TAYLOR,

*Plaintiff,*

—vs—

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,

*Defendants.*

PROOF OF MAILING

STATE OF MICHIGAN )  
 ) ss:  
COUNTY OF WAYNE )

Phyllis D. Porter, first being duly sworn, deposes and says that she did serve a true copy of the within ANSWER upon:

John P. Hergt, Esq.  
Donnelly & Associates, P.C.  
2066 City National Bank  
Building  
Detroit, Michigan 48226

Daniel G. Galant, Esq.  
General Motors Corp.  
General Motors Bldg.  
Detroit, Michigan 48202

by placing same in properly addressed sealed envelopes and depositing same in the U.S. Mails at the First National Building, Detroit, Michigan on this 14th day of July, 1981 with postage thereon fully prepaid.

/s/ Phyllis D. Porter  
PHYLLIS D. PORTER

Subscribed and sworn to before me this 14th day of July, 1981.

/s/ Denise M. Gatto  
DENISE M. GATTO  
Notary Public  
Wayne County, Mich.  
My Commission Expires  
Sept. 11, 1983

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

HON. CHARLES W. JOINER

ARTHUR TAYLOR,

v.

*Plaintiff,*

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

MOTION TO REMAND

ARTHUR TAYLOR, the Plaintiff in the above case, removed to this Court by the aforesaid Defendants, moves to remand the above matter to the Circuit Court for the County of Wayne, State of Michigan, the court in which this matter was pending at the time of such removal, upon the following grounds:

1. Plaintiff denies the allegations of the petition for removal that this Court has original jurisdiction in this case; the allegations contained in Plaintiff's Complaint do not arise under the Constitution, laws or treaties of the United States, as required by 28 USC 1331. Further, Plaintiff denies that this case is one which may be removed pursuant to 28 USC 1441.

2. Plaintiff specifically alleges that the complaint filed in Wayne County Circuit Court sets forth two counts. The first count is based on a breach of public policy, said breach consisting of Plaintiff's improper discharge from his employment in retaliation for filing a Worker's Compensation claim and in retaliation for having medical restrictions placed on him. The second count alleges a breach of insurance contract, said contract providing that

Plaintiff was to receive salary continuation and/or disability benefits if Plaintiff became totally disabled and unable to work. At a time when Plaintiff was totally disabled, unable to work and totally dependent on said monthly benefits, said benefits were wrongfully and maliciously discontinued.

3. This court is without original jurisdiction over either of these state claims, and the cause herein was improperly removed out of the Wayne County Circuit Court, the Court with proper jurisdiction.

4. That Plaintiff further denies his claim is removable pursuant to the provisions of the Employee Retirement Income Security Act (ERISA), for the breach of public policy and breach of insurance contract claims are not alleged to have arisen under ERISA.

5. The cause herein was improperly removed in that the matters asserted in the Complaint filed in Wayne County Circuit Court did not represent a claim or right arising under the Constitution, laws or treaties of the United States.

6. Respondent herein further moves this Court to order the payment to the Plaintiff by the Defendants of all costs and disbursements incurred by reason of the removal proceedings.

WHEREFORE, the Plaintiff prays that this case be remanded to Wayne County Circuit Court, in accordance with the requirements of 28 USC 1447(c).

DONNELLY & ASSOCIATES, P.C.  
Attorneys for Plaintiff

By: \_\_\_\_\_

RUDY J. HUIZENGA (P-26718)  
2066 City National Bank Building  
Detroit, Michigan 48226  
(313) 963-4200

April 3, 1981

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

---

THE HON. CHARLES W. JOINER

ARTHUR TAYLOR,  
*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

---

BRIEF IN SUPPORT OF MOTION TO REMAND

Plaintiff contends that the instant case was improperly removed to this Court, and therefore should be remanded to Wayne County Circuit Court, where the case was originally filed.

The guidelines for remand are contained in 28 USC 1447(c), which states:

"If at any time before final judgment it appears the case was removed improvidently and without jurisdiction, the district court shall remand the case, and may order the payment of just costs. A certified copy of the order to remand shall be mailed by its clerk to the clerk of the State court. The State court may thereupon proceed with such case."

Plaintiff's complaint alleges two causes of action, neither of which raises the federal question which is necessary to remove this case. The first count of Plaintiff's complaint alleges that Defendant improperly discharged

Plaintiff from his employment in retaliation for (a) having medical restrictions placed on him and (b) filing a worker's compensation claim against the Defendant. Plaintiff alleges a breach of Michigan public policy, and Michigan law should govern this issue, there being no federal question involved. Further, Plaintiff contends that ERISA in no way effects or applies to this state claim.

Plaintiff's second claim alleges a breach of insurance contract. As explained in the Motion for Remand, said contract provides that Plaintiff was to receive salary continuation and/or disability benefits if he became disabled and unable to work, but said monthly benefits were wrongfully discontinued. 29 USC § 1144 provides that federal law will supersede state laws "... insofar as they may now or hereafter relate to any employee benefit plan..." Plaintiff does not contend that Defendant's actions violate any state law in regard to an employee benefit plan; rather, Plaintiff alleges a simple breach of insurance contract, an action not intended to be precluded or superseded by ERISA.

Further, it must be emphasized that in interpreting ERISA, courts have set guidelines in regard to what actually is preempted by ERISA. Courts have not found breaches of insurance contracts to be within the state law which is preempted by ERISA. Congress intended ERISA to preempt state law such as states health care service plan that directly regulates employee benefit plans. *Hewlett Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831. ERISA does not preempt application of state law to group insurance policies when such policies are purchased by employee benefit plans. *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980. Plaintiff contends that the intent behind ERISA was not to bar breach of contract claims from being heard in state courts.

Because the allegations in Plaintiff's Complaint do not arise under the Constitution, laws or treaties of the United States, or under ERISA. Plaintiff contends that that case was removed "improvidently and without jurisdiction," and prays that this Honorable Court remand this matter to Wayne County Circuit Court.

DONNELLY & ASSOCIATES, P.C.  
Attorneys for Plaintiff

By: \_\_\_\_\_  
RUDY J. HUIZENGA (P-26718)  
2066 City National Bank Building  
Detroit, Michigan 48226  
(313) 963-4200

April 3, 1981

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

ARTHUR TAYLOR,  
v. *Plaintiff,*

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a foreign corporation, jointly and severally,  
*Defendants.*

PROOF OF SERVICE

BRIAN BERGER, being first duly sworn, deposes and says that on the 3rd day of April, 1981, he served copies of Notice of Hearing, Motion to Remand, Brief in Support of Motion to Remand and Proof of Service upon:

Michael G. Vartanian, Esq.  
800 First National Building  
Detroit, Michigan 48226

David M. Davis, Esq.  
General Motors Corporation  
3044 West Grand Boulevard  
Detroit, Michigan 48202

by hand delivering said copies to the respective offices of Mr. Vartanian and Mr. Davis at the addresses above-stated.

Further, deponent sayeth not.

/s/ Brian Berger  
BRIAN BERGER

Sworn to and subscribed before  
me this 3rd day of April, 1981

/s/ Susan M. Bednard,  
SUSAN M. BEDNARD, Notary Public  
Wayne County, Michigan  
My Commission expires: 8-19-84.

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

HON. CHARLES W. JOINER

ARTHUR TAYLOR,

v.

*Plaintiff,*

GENERAL MOTORS CORPORATION, a foreign corporation,  
and METROPOLITAN LIFE INSURANCE COMPANY, a for-  
eign corporation, jointly and severally,  
*Defendants.*

NOTICE OF HEARING

To: DAVID M. DAVIS, ESQ.

General Motors Corporation  
3044 West Grand Boulevard  
Detroit, Michigan 48202

MICHAEL G. VARTANIAN, ESQ.  
800 First National Building  
Detroit, Michigan 48226

PLEASE TAKE NOTICE that the Plaintiff's Motion to Remand, attached hereto, will be brought on for hearing before the Honorable Charles W. Joiner, in his courtroom, Room 251 Federal Building, 231 Lafayette Boulevard, Detroit, Michigan 48226, on Tuesday, April 14, 1981, at 3:00 p.m. or as soon thereafter as counsel may be heard.

DONNELLY & ASSOCIATES, P.C.  
Attorneys for Plaintiff

By: /s/ Rudy J. Huizenga  
RUDY J. HUIZENGA (P-26718)  
2066 City National Bank  
Building  
Detroit, Michigan 48226  
(313) 963-4200

April 3, 1981

LETTER (WITH ATTACHMENTS) FROM  
GENERAL MOTORS TO JUDGE JOINER  
FILED APRIL 28, 1981

GENERAL MOTORS CORPORATION

April 28, 1981

Honorable Charles W. Joiner  
U.S. District Court  
Eastern District of Michigan  
Federal Building  
231 Lafayette Boulevard  
Detroit, Michigan 48226

Re: *Arthur Taylor v. General Motors  
Corporation and Metropolitan Life  
Insurance Company, No. 81-70939*

Dear Judge Joiner:

Enclosed please find the booklet entitled "Your GM Benefits" and a copy of the Group Insurance Certificate issued by the Metropolitan Life Insurance Company. Both the booklet and the Group Certificate issued thereunder constitute the plan document for purposes of the Employee Retirement Income Security Act of 1974.<sup>1</sup>

Plaintiff in his latest memorandum attempts to characterize his action as only a state action for breach of an insurance contract and cites in support of such proposition *Lederman v. Pacific Mutual Life Insurance Co.*, 494 F.Supp. 1020 (C.D. Cal. 1980) and *Cate v. Blue Cross and Blue Shield of Alabama*, 434 F.Supp. 1187 (E.D. Tenn. 1977).

Plaintiff's Complaint at Count II seeks more than benefits under a mere insurance contract. Paragraph 23

<sup>1</sup> The booklet "Your GM Benefits" refers to Insurance certificates of various carriers for the detached provisions of benefits coverages. See Page 46 of the booklet.

of the Complaint refers to the 1980 General Motors Personal Benefit Summary and specifically seeks entitlement to:

**Salary Continuation Benefits**

**Sickness and Accident Disability Benefits**

These disability coverages are described commencing at page 28 of the booklet "Your GM Benefits." Only the Sickness and Accident Disability Benefit is described and governed by the Metropolitan Group Certificate. The Salary Continuation Benefit is payable solely by General Motors Corporation and supplements the sickness and accident benefit for a period of twenty-six weeks (for employees with ten or more years of service), see page 31 of the booklet "Your GM Benefits." Therefore, Plaintiff seeks more than benefit entitlement under an insurance contract.

Further, the booklet, on page 49, as required by ERISA, identifies the Named Fiduciary and the Plan Administrator of the benefit plans described therein:

*Named Fiduciary*

The Finance Committee of General Motors Corporation is the named fiduciary of the plans described in this booklet.

*Administrator*

General Motors Corporation is the sponsoring employer and administrator of the benefit plans described in this booklet. The Administrator's address is Room 13-266, General Motors Building, Detroit, Michigan 48202.

Additionally, the Metropolitan Group Certificate at page (2) under the heading "Notice to the Employee" provides in relevant part:

"Effective January 1, 1981, any monthly instalments payable under the Total and Permanent Disability

Benefits provision for disability commencing on or after that date are provided under Group Policy No. 14000-G(T), and any benefits payable under the Sickness and Accident Insurance for disability occurring on or after that date, and any benefits payable under the Extended Disability Benefit Insurance for disability commencing on or after that date are provided under Group Policy No. 18501-G(T), and such benefits are primarily the liability of the Policyholder under said Group Policies. The Insurance Company is liable for such benefits to the extent that they are not the liability of the Policyholder, and the Group Policies specify the time when, and the circumstances under which, the Insurance Company is so liable. The Insurance Company continues to determine all benefit payments in accordance with the terms and conditions of such Group Policies."

Thus General Motors Corporation, the policyholder, remains primarily liable for the payment of disability benefits that Plaintiff is seeking by his Complaint.

*I. Plaintiff Has Stated a Claim Under ERISA*

Plaintiff contends that his Complaint fails to state a claim under federal law and further that even if his claim was cognizable under ERISA the Plaintiff has the choice of the forum.

The Court in determining the intent of Congress in drafting ERISA § 502, 29 U.S.C. § 1132 must be guided by the Conference Committee Explanation of P.L. 93-406:

"The U.S. district courts are to have exclusive jurisdiction with respect to actions involving breach of fiduciary responsibility as well as exclusive jurisdiction over other actions to enforce or clarify benefit rights provided under Title I. However, with re-

spect to suits to enforce benefit rights under the plan or to recover benefits under the plan which do not involve application of the Title I provisions, they may be brought not only in U.S. district courts but also in State courts of competent jurisdiction. All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor Management Relations Act of 1947. The U.S. district courts are to have jurisdiction of these actions without regard to the amount in controversy and without regard to the citizenship of the parties." 1974 U.S. Cong. & Adm. News, p. 5107 (emphasis added).

Thus Congress intended the courts to be guided by the body of decisional law developed under Section 301 of the Labor Management Relations Act, LMRA, 29 U.S.C. § 185.

Decisions under LMRA § 301, 29 U.S.C. § 185, reveal the primacy of the federal judiciary in deciding questions of federal law. The District Court in *Glaziers, Glass Workers of Jacksonville, Florida v. Florida Glass & Mirror of Jacksonville, Inc.*, 409 F.Supp. 225 (M.D. Fla. 1976) enunciated the proper judicial focus in determining whether a claim under Section 301 had been pleaded:

"Obviously, it is not necessary for a complaint to expressly declare that the cause of action arises under Section 301 in order for the case to be removable properly to federal court. To so hold would enable a shrewd plaintiff to deliberately circumvent and thwart the jurisdiction of a federal district court through carefully drawn pleadings that omitted any reference to the statutory jurisdictional basis. *Haynes v. Schmidt & Sons, Inc.*, [374 F.Supp.] at 445 (M.D. Pa. 1974). It is the reality of the controversy, not the form of the pleadings, that determine whether the court has jurisdiction under Sec.

301. Issues involving federal labor law are cognizable under Sec. 301, despite the absence of any reference in the complaint to the court's jurisdiction under Section 301. *Haynes v. Schmidt & Sons, Inc.*, *supra*, at 445; *Talbot v. National Super Markets of La.* 372 F.Supp. 1050 (E.D. La. 1974); *Roper Corp. Newark Div. v. Farrow*, 300 F.Supp. 103, 104 (S.D. Ohio 1969). Moreover, such a view would frustrate the preemptive supremacy of federal labor law. *Avco Corp. v. Aero Lodge 735, Int'l Ass'n of Machs. & Aerospace Workers*, 376 F.2d 337, 340 (6th Cir. 1967), *aff'd* 390 U.S. 557, 560, 88 S.Ct. 1235, 20 L.Ed.2d 126 (1968); *Haynes v. C. Schmidt & Son*, *supra*, at 495; *Roper Corp., Newark Div. v. Farrow*, *supra*, at 104-05. Hence, if the complaint raises issues involving national labor law, the court's jurisdiction under Sec. 301 is properly invoked for removal." 409 F.Supp. at 225. (emphasis added).

Removal of a case from state court to Federal District Court is "one aspect of 'the primary of the federal judiciary in deciding questions of federal law.'" See *England v. Medical Examiner*, 375 U.S. 411, 415-416." *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557, 560 (1968). Removal is possible where the state suit is within the "original jurisdiction" of the District Court within the meaning of 28 U.S.C. Sections 1441 (a) and (b). The District Court pursuant to 28 U.S.C. Section 1337 has "original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce . . ." As noted by the *Avco* Court, "It is that original jurisdiction that a Section 301 action invokes." 390 U.S. at 562. Accord: *Boys Markets, Inc. v. Retail Clerks Union, Local 770*, 398 U.S. 235, 244 (1970) and *Berry v. Michigan Bell Telephone Co.*, 319 F.Supp. 401, 402 (E.D. Mich 1967).

Recently, the Court of Appeals, Ninth Circuit, in *Friscoe v. Reynolds Metals Co.*, 615 F.2d 1209 (9th Cir.

1980) referring to the complaint filed therein concluded that federal jurisdiction was present based on the nature of the action:

"Fristoe contends his original state court complaint did not confer federal subject matter jurisdiction.

Although he had not mentioned LMRA § 301 in the complaint, and stylized his causes of action in common law terms, the court questioned him carefully to determine nature of his claims. It is apparent from the allegations in his complaint and his responses to the court's questions that Fristoe was alleging that Reynolds wrongfully discharged him in breach of the collective bargaining agreement and that the union improperly handled his grievance.

Mere omission of reference to LMRA § 301 in the complaint does not preclude federal subject matter jurisdiction. The court's recharacterization of Fristoe's complaint as one arising under § 301 is required by federal preemption doctrines." 615 F.2d at 1212.

The Ninth Circuit in determining that plaintiff's action arose under LMRA § 301, cited the Sixth Circuit's opinion in *Avco Corp. v. Aero Lodge No. 735, supra*,

"On similar facts, the Sixth Circuit concluded:

We cannot accept the basic premise of Avco's argument that its action is based solely upon a State created right. Section 301 of the Labor Management Relations Act, 29 U.S.C., Section 185, confers jurisdiction upon the District Court . . . to enforce collective bargaining agreements in industries affecting interstate commerce. *Textile Workers Union of America v. Lincoln Mills*, 353 U.S. 448, 77 S.Ct. 913, 1 L.Ed.2d 972, 40 LRRM 2113 (1957), held that Federal substantive law preemptively applies in suits under Section 301 . . .

\* \* \*

Thus, according to the findings of the Supreme Court, as enunciated in *Lincoln Mills, supra*, and expanded in *Lucas Flour Co., supra*, all rights and claims arising from a collective bargaining agreement in an industry affecting interstate commerce arise under Federal law. State law does not exist as an independent source of private rights to enforce collective bargaining contracts. While State courts may have concurrent jurisdiction, they are bound to apply Federal law. . . . The force of Federal preemption in this area of labor law cannot be avoided by failing to mention Section 301 in the complaint.

*Avco Corp. v. Aero Lodge No. 735, Int'l. Ass'n of Machinists and Aerospace Workers*, 376 F.2d 337, 339-40, 65 LRRM 2193 (6th Cir. 1967) aff'd, 390 U.S. 557, 88 S. Ct. 1235, 20 L.Ed.2d 126, 67 LRRM 2881 (1968)." 615 F.2d at 1212.

Thus applying the body of decisional law developed under 29 U.S.C. § 185 and recognizing the congressional mandate to the federal courts to develop a federal body of pension law, see ERISA § 514, 29 U.S.C. 1144, it is clear that Plaintiff has stated a claim under ERISA § 502 "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." The federal district courts have original jurisdiction over the action and thus under 28 U.S.C. § 1441(b) may be removed by this defendant to the U.S. federal district court.

Plaintiff's reliance on *Lederman v. Pacific Mutual Life Insurance Co.*, 494 F.Supp. 1020 (C.D. Cal. 1980); *Austin v. General American Life Insurance Co.*, 498 F.Supp. 844 (N.D. Ala. 1980); and *Cate v. Blue Cross and Blue Shield of Alabama*, 434 F.Supp. 1183 (E.D. Tenn. 1977) is misplaced.

The *Lederman* decision involved a claim against an insurance company on a medical policy for nursing fees. The Court in *Lederman* found no ERISA claim. Further, the portion of the opinion interpreting ERISA § 502 (a) (1) (B), 29 U.S.C. 1132(a) (1) (B), to allow Plaintiff his choice of forum and deny the Defendant the right of removal is erroneous. The Court failed to distinguish between "original" jurisdiction and "concurrent" jurisdiction and further failed to recognize the congressional intent to follow well established federal decisional law under LMRA § 301, 29 U.S.C. § 185; such body of law clearly provides the Defendant an absolute right of removal under 28 U.S.C. § 1441(b) for actions which may be originally brought in federal court.

Likewise the *Cate* decision, *supra*, and the *Austin* decision, *supra*, involved narrow claims against an insurance company under state law. The *Cate* decision recognized that federal jurisdiction would exist when the claims were against the parties responsible for administering the employee benefit plan:

"It is clear from this declaration of policy and from the structure of the Act, that the focus of Congress was on the 'conduct, responsibility and obligation' of those who were responsible for administering employee benefit plans. Having established a new body of federal rights and obligations, Congress added to the jurisdiction of the federal courts in order to further the legislative purpose. For this reason, it preempted state laws insofar as they related to employee benefit plans § 1144. (footnote omitted)." 434 F.Supp. at 1190.

General Motors is the administrator of the GM Insurance Program; General Motors is primarily liable for the payment of disability benefits thereunder; General Motors is solely responsible for the administration, eligibility determinations and payment of Salary Continuation Bene-

fits; and the Finance Committee of General Motors Corporation is the Named Fiduciary of the Insurance Program.

Plaintiff's action is more than a claim under a mere insurance contract against an insurance company.

#### I. Conclusion

For all of the above reasons and for reasons set forth in the prior memorandum submitted by General Motors Corporation, this Defendant prays that Plaintiff's motion to remand be denied.

Respectfully submitted,

OTIS M. SMITH  
General Counsel

By

DAVID M. DAVIS  
Attorney  
Office of the General Counsel

DMD/bkh

cc: Mr. John P. Hergt, Esq.  
Mr. Philip M. Frost, Esq.

[Picture Omitted in Printing]

## YOUR GM BENEFITS

A Handbook for Salaried Employees in the United States

## NOTICE TO SALARIED EMPLOYEES

On July 1, 1980, the Savings-Stock Purchase Program was modified temporarily to make the GM contribution \$.30 for each \$1.00 of your savings up to 10% of your eligible salary. Accordingly, the higher rate of GM contributions described in this booklet ceased to be applicable after June 30, 1980.

## GENERAL MOTORS CORPORATION

### AS A GENERAL MOTORS SALARIED EMPLOYEE . . .

you have one of the finest and most comprehensive employee benefit packages in industry. General Motors has been and continues to be a leader in providing a broad range of benefit programs to protect employees and their families. Today's GM benefits are an important factor in making your life more enjoyable and the future for yourself and your family more secure. This booklet highlights benefits which apply to GM salaried employees working in the United States.

*This booklet presents general information only and is designed to give you a broad picture of some of the added values of working with General Motors. Any reference to the payment of benefits is conditioned upon your eligibility to receive them. Each of these programs has its own terms and conditions which in all respects control the benefits provided.*

The Savings-Stock Purchase Program and Employee Stock Ownership Plan are subject to receipt of acceptable governmental rulings.

Group insurance benefits described in this booklet generally are provided to salaried employees of General Motors actively at work on or after September 17, 1979.

## HOW TO FIND THE INFORMATION YOU WANT—

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## IF YOU HAVE HEALTH CARE EXPENSES

The Insurance Program provides protection for you and your eligible dependents against a wide range of Health Care expenses while you are an active employee and after your retirement. The basic coverages are identical to those provided most hourly employees. The Comprehensive Medical Expense Insurance Program is additional coverage for salaried employees which provides major medical benefits over and above those available under the basic coverages.

Coverages for benefits shown below are provided through various carriers such as local Blue Cross and Blue Shield plans, the Metropolitan Life Insurance Company, and the Connecticut General Life Insurance Company.

Alternative coverage, providing benefits which may differ from those shown below, is offered in some areas at employee option through a health maintenance organization (HMO) or other group practice plan. Descriptive materials of benefits provided under alternative coverages are available at the insurance office at your GM employing location and from the HMO or group practice plan.

## BASIC HEALTH CARE COVERAGES

Hospital Coverage Provides . . .

payment of charges for:

- up to 365 days of needed care in a semi-private room in a participating hospital for general conditions, including maternity care;
- up to 45 days of needed care in a hospital for nervous and mental conditions, or in an approved residential substance abuse treatment facility;
- up to 730 days of needed care (other than custodial care) in an approved nursing home for general conditions—up to 90 days for nervous and mental conditions;

- most medical needs in a hospital or approved facility, such as supplies, drugs, dressings, anesthesia, x-ray, laboratory tests, intensive care, and routine nursery care;
- most services in the outpatient department of a hospital, such as treatment of accidental injuries and certain medical emergencies, surgery, physical therapy (up to 60 treatments per condition per year, which also may be performed in an approved facility other than a hospital), and use of an artificial kidney machine, iron lung and similar equipment;
- up to 35 outpatient treatments per year in an approved substance abuse treatment facility (limited to 140 lifetime treatments);
- medically necessary transfers by ambulance between hospitals and for transfers from hospitals to approved facilities for a CAT scan;
- services under approved home care programs, including payment for necessary skilled nursing and home health aides;
- up to \$1,000 per calendar year for outpatient psychiatric services when billed by an approved facility (see next section);
- up to \$100 per day for room, board, and all covered services in a non-participating general acute care hospital (up to \$15 per day for other than a general acute care hospital).

#### Medical-Surgical Coverage Provides . . .

payment of reasonable and customary charges for:

- surgery and anesthesia, including pre- and post-operative care;
- obstetrical delivery, including pre- and post-natal care;

- inhospital consultation and technical surgical assistance;
- inhospital medical care by the doctor in charge of the case and doctor's medical visits at the rate of two per week for up to 730 days in an approved nursing home for general conditions;
- radiation therapy and chemotherapy for malignant conditions;
- necessary diagnostic x-rays, laboratory, and pathology services;
- laboratory testing for an annual pap smear;
- outpatient treatment of accidental injuries and certain medical emergencies;
- outpatient psychiatric services, including family counseling (subject to a copayment of 10% for the sixth through the tenth visits and a 25% copayment for all subsequent visits) and benefits of up to \$75 for psychological testing. Payment is limited to \$1,000 per calendar year in combination with expenses for outpatient psychiatric services in an approved facility.

#### Prosthetic and Durable Medical Equipment Benefits

Hospital and medical-surgical coverages provide for the purchase, fitting, and repair of certain external prosthetic appliances which replace a body part or the functions of a permanently malfunctioning body part. These prosthetic appliances must be prescribed by a licensed physician and furnished and billed by a hospital or facility approved by the carrier.

Benefits are also provided for the purchase or rental of certain durable medical equipment (such as hospital beds, crutches, or wheelchairs) when prescribed by a licensed physician. This equipment must be necessary for the treatment of a medical condition and be provided

and billed by a hospital, nursing home, or professional provider such as a pharmacy or medical supply house.

#### Prescription Drug Benefits

Benefits are provided for the purchase of drugs which require prescription by a licensed physician under federal law. Benefits also are provided for injectible insulin and disposable syringes and needles when prescribed to inject the insulin. A \$3 copayment is applicable for each prescription order or refill.

Drug quantities are limited to a maximum of a 34-day supply per prescription, except for certain maintenance drugs which may be dispensed in 100 or 200 unit doses. Disposable syringes and needles are limited to a 1-month supply when prescribed with a 1-month supply of insulin or, if greater, 100 syringes and needles when prescribed with a 3-month supply of insulin.

Drugs purchased from a participating pharmacy will be billed directly to the carrier. If drugs are purchased from a non-participating pharmacy, you will be required to pay the full charge. You then should file a claim with your carrier. You will be reimbursed 75% of the reasonable and customary charge, less the \$3 copayment for each prescription.

#### Hearing Aid Benefits

To obtain benefits you must first be examined by an ear specialist (otologist or otolaryngologist) to determine if your hearing problem is caused by a condition which may be corrected by use of a hearing aid. *The cost of this examination is not a covered service.*

If it is determined that your hearing problem may be corrected by use of a hearing aid, benefits will be provided for the reasonable and customary charges for the following services only when obtained from a participating provider once during any period of 36 consecutive months:

- audiometric examination;
- hearing aid evaluation test (up to \$48, subject to change each October); and
- one hearing aid (acquisition cost and dispensing fee). However, only the particular hearing aid prescribed as a result of the hearing aid evaluation test will be covered.

Covered benefits will include an ear mold, necessary fitting and adjustment of the hearing aid, and a follow-up examination to determine the effectiveness of the hearing aid.

#### Dental Coverage

Benefits will be provided up to an annual maximum of \$1,000 per person for other than orthodontics (teeth straightening) during any benefit year (October 1 through September 30), and up to a lifetime maximum of \$800 per person for orthodontics for individuals under age 19.

Metropolitan Life Insurance Company is the dental carrier for Michigan employees, retirees and eligible surviving spouses. Connecticut General Life Insurance Company is the dental carrier for employees, retirees and eligible surviving spouses from employing locations outside Michigan. Benefits are based on reasonable and customary charges of all dentists as determined by the carrier.

#### Covered Dental Services

Benefits are payable at 100% of the reasonable and customary charge for:

- oral examinations and prophylaxis (cleaning of teeth), but not more than twice in any benefit year;
- topical application of fluoride for persons under age 20;
- emergency treatment for temporary relief of pain.

Benefits are payable at 90% of the reasonable and customary charge for:

- dental x-rays, including full mouth x-rays (but not more than once in any period of 36 consecutive months), and bitewing x-rays (but not more than twice in any benefit year);
- extractions and oral surgery;
- amalgam, silicate, acrylic, synthetic porcelain, and composite fillings;
- general anesthetics and intravenous sedation when medically necessary and administered in connection with oral or dental surgery;
- endodontic (nerve and pulp) and periodontal (gum) treatment;
- repair of crowns, bridgework or dentures; and relining or rebasing of dentures more than six months after installation, but not more than one relining or rebasing in any period of 36 consecutive months;
- inlays, onlays, gold fillings, or crowns, but only when the tooth cannot be restored with an amalgam or other filling.

The remaining 10% of the reasonable and customary charge is a copayment payable by you.

Benefits are payable at 50% of the reasonable and customary charge for:

- initial installation of fixed bridgework;
- initial installation of removable dentures, including any adjustments during the six month period following installation;
- replacement of an existing denture or fixed bridgework, but only when:

- (a) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed; or
- (b) the existing denture or bridgework cannot be made serviceable and, if it was installed under this coverage, at least five years have elapsed prior to the replacement; or,
- (c) the existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture;
- orthodontic (teeth straightening) procedures and treatment (including related oral examinations) for persons under age 19.

The remaining 50% of the reasonable and customary charge is a copayment payable by you.

#### Vision Coverage

Benefits will be provided for the reasonable and customary charges (less copayment) for:

- vision examination by an ophthalmologist or optometrist once during any period of 12 consecutive months (\$5 copayment). Under certain limited conditions a benefit may be payable for a second examination within 60 days of the first examination;
- lenses once during any period of 12 consecutive months (\$7.50 copayment);
- contact lenses when vision cannot be corrected to 20/70 in the better eye except by their use or when certain irregularities in the shape of the eye require their use (\$7.50 copayment). When contact lenses are prescribed for any other reason, \$35 less the \$7.50 copayment will be the maximum benefit. Benefits will be provided for the reasonable and customary charges

(less copayment) for contact lenses following cataract surgery unless otherwise provided under medical-surgical coverage.

- frames will be provided once during any period of 24 consecutive months (\$7.50 copayment). If you obtain your frames from a participating provider and you select frames from a display the provider will show you, there will be no expense to you other than the copayment. However, if you select frames not included in the display, or obtain your frames from a non-participating provider, up to \$15 less the \$7.50 copayment will be the maximum benefit.

The total copayment for each covered individual during any period of 12 consecutive months will not exceed \$12.50 (\$5 for a vision examination and \$7.50 for lenses and frames combined).

#### COMPREHENSIVE MEDICAL EXPENSE INSURANCE PROGRAM

Comprehensive medical expense insurance coverage provides you, your eligible dependents, retirees, and eligible surviving spouses with major medical benefits. This coverage is offered through the Connecticut General Life Insurance Company. It adds to the protection you are provided by the basic coverages described earlier.

You pay part of the cost of this additional coverage, based on the schedule below. General Motors pays the major portion of the cost.

##### Monthly Contributions

Coverage	Active Employee	Retiree or Surviving Spouse
	\$	\$
Single	.45	1.15
Two Party	1.10	2.25
Family	1.30	2.75

#### Major Medical Benefits

Major medical benefits offer additional protection when the basic benefits described earlier have been exhausted or are not applicable.

Major medical benefits cover reasonable charges, less a deductible amount as described later, for necessary medical services and supplies, including those listed which are not generally covered by your basic coverages:

- physicians' non-surgical services out of hospital;
- up to \$25 a day toward the difference in cost between a semi-private and a private hospital room;
- professional private duty nursing care (up to \$25 a day when care is determined to be primarily custodial in nature);
- blood;
- professional ambulance service when medically necessary;
- semi-private hospital charges after the maximum duration allowed under basic coverages (generally 365 days) has been exhausted;
- semi-private nursing home charges for acute therapeutic care after the maximum duration allowed under basic coverages (generally 730 days) has been exhausted;
- dental work and dentures made necessary by an accident (to the extent not covered under the dental plan);
- inoculations;
- physical examinations (limited to one a year for persons over age 6) including laboratory tests;
- chiropractic services (up to 20 visits within the initial 3 months of treatment);
- voluntary sterilizations;

- copayments made under basic coverage for prescription drugs;
- up to \$150 a day, less amounts payable by basic coverages, for confinement in a hospital operated primarily for care of nervous or mental conditions;
- up to \$25 a day for custodial care in an approved facility, or for custodial care rendered at home by a professional private duty nurse.

#### Deductible Amount

You pay a deductible amount of \$50 toward covered expenses which are incurred each calendar year for the same individual. This \$50 is called the individual deductible amount. In meeting this amount, you can add up all your covered expenses for the same individual, whether they relate to one condition or to a number of different conditions.

However, if covered expenses incurred by two or more family members equal \$100 (the family deductible amount), no additional deductible amount will be applied against expenses incurred by any of your other family members for that calendar year. No more than \$50 of covered expenses for one family member can be applied toward the \$100 family deductible amount.

Any covered expenses incurred in October, November or December of any calendar year which are applied to the deductible amount for that year and therefore are not reimbursable will not be applied to the deductible amount for the following calendar year.

**After You Pay  
the Deductible Amount,  
Your Insurance Pays 80% . . .**

of the next \$2,500 of covered expenses incurred during one calendar year and 100% of covered expenses which

exceed \$2,500. Covered expenses for outpatient psychiatric care continue to be payable at 80%, however.

#### Calendar Year Benefit Limitations

Covered expenses for outpatient psychiatric care include only those charges for services rendered after all basic benefits have been exhausted. Reimbursement is limited to \$4,000 per year for non-psychotic conditions.

Covered expenses for outpatient allergy testing and treatment are limited to benefits of \$2,000 per year.

The maximum reimbursement amount is \$50,000 per calendar year for each individual. There is no lifetime maximum.

#### GENERAL INFORMATION ABOUT YOUR HEALTH CARE COVERAGES

##### Effect on Medicare

If you or one of your dependents is enrolled for Medicare, the GM basic Health Care and major medical benefits will be reduced by benefits payable for the same services under Medicare. It is important for both you and your spouse to enroll for Medicare when first eligible. In the event of your death, your surviving spouse will not be eligible for Corporation contributions for any GM Health Care coverages if he or she is eligible but not enrolled for Medicare Part B at or after age 65.

You become eligible for Medicare at age 65, whether or not you choose to continue working. However, if you continue working after age 65, Social Security will not notify you of your eligibility to enroll for Medicare. It is your responsibility to contact the local Social Security Office to apply for Medicare if you continue to work after age 65. It is suggested this contact be made three months prior to attaining age 65. This will allow sufficient time to process your application so you will not miss your initial opportunity for enrollment. If you do not enroll for

Medicare when first eligible, there is a 10% penalty in the monthly amount of the Medicare Part B premium cost to you for each year you delay enrolling.

#### Coordination of Benefits

A coordination of benefits provision is included in all Health Care coverages under the GM Insurance Program. As a result, benefits payable under this Program, when combined with any other group plan benefits, are limited to the total allowable expenses incurred by the patient during any claim determination period. The purpose of this provision is to avoid duplicate payment of benefits in the event an individual is covered by more than one employer plan.

#### Sponsored Dependents

Your sponsored dependents (generally aged parents) may have the same Health Care coverages as you have except that dental, vision and major medical coverages are not available to sponsored dependents. You pay the full cost for sponsored dependent coverages.

#### Exclusions and Limitations

Certain services and charges with respect to Health Care coverages are excluded or limited. A complete description of exclusions and limitations applicable to each benefit provided under the GM Health Care coverages may be found in the appropriate benefit certificates and any riders thereto or similar documents provided by the carriers.

#### How to Claim Benefits

##### Basic Hospital, Medical-Surgical, and Prescription Drug Claims

If your carrier is a Blue Cross or Blue Shield plan, just show your identification card when you go to the hospi-

tal, residential or outpatient treatment facility, physician, or other provider of covered services. No deposit should be required for covered services in Blue Cross participating hospitals or approved facilities. The hospital or facility is paid directly by Blue Cross. Blue Shield generally pays physicians directly. In any situation where a provider of a service is not paid directly by Blue Cross-Blue Shield, you should submit the charges to your local Blue Cross-Blue Shield plan office.

If your carrier is Metropolitan Life Insurance Company, obtain a claim form from the insurance office at your GM employing location or Metropolitan Life. Complete the upper portion of the form and have the hospital, residential or outpatient treatment facility, physician, or other provider of covered services complete the lower portion. Either you or the provider can submit the completed form to Metropolitan Life. Payment will be made directly to the provider unless you have paid all or part of the charges for service. In that case, Metropolitan Life will pay you. In the case of hospital coverage provided by Metropolitan Life, payment will be made to you, unless you authorize Metropolitan Life to pay the facility directly.

#### Hearing Aid Claims

Participating providers generally will have the necessary claim forms and will be paid directly by the carrier. Benefits are payable only if you obtain hearing aid services from a participating provider. Ask the provider if he or she is participating BEFORE you receive services. If you need the name of a participating provider, inquire at your GM employing location, the Blue Shield plan in which you are enrolled, or Metropolitan Life, as may be applicable.

#### Dental Claims

Dental claim forms and instructions are available to dentists in areas where General Motors has employees.

In addition, claim forms are available at the insurance office at your GM location and from the carrier for your area.

If a course of treatment is expected to involve dental expenses amounting to \$200 or more, your dentist should file with the carrier a description of the procedures to be performed and an estimate of the charges prior to the commencement of treatment.

The carrier will notify the dentist of estimated benefits payable with consideration given to alternate procedures that may be performed in order to accomplish the desired results.

You should discuss with your dentist the treatment plan, the fee, and the estimated dollar amount of benefits BEFORE treatment begins.

#### Vision Claims

Metropolitan Life Insurance Company is the vision coverage carrier for all employees. A claim form may be obtained from the insurance office at your GM location or from a participating provider. Complete your portion of the form and have the remaining portion completed by the provider. The completed form should be sent to Metropolitan Life. Benefits will be paid directly to the provider to the extent that you have not paid all or part of the charges for services. In that case, Metropolitan Life will pay you.

#### Comprehensive Medical Expense Insurance Program Claims

You should file a claim when your out-of-pocket expenses exceed the \$50 deductible amount for an individual or \$100 for your family. However, if your covered expenses are small, you may find it more convenient to postpone

filing until the end of the calendar year. *In any event, claims should be filed no later than 90 days following the end of the calendar year in which expenses were incurred.*

When you are ready to file a claim, you should obtain the necessary forms from your insurance office. There are things you should do routinely before you reach the point when you know you will have a claim to file:

- keep all bills and receipts for medical services incurred by you or your insured dependents;
- keep bills and receipts properly identified, separated by individuals, and in chronological order;
- see that bills or receipts are itemized and include patient's name, description of service or medical supply, date of service or purchase, and charges incurred;
- keep basic coverage vouchers, and if applicable, Medicare Explanation of Benefit vouchers, with appropriate bills or receipts;
- be sure drug receipts include prescription number, name of patient, date of purchase and amount of charge;
- be sure that receipts for medical supplies, equipment, private duty nursing, physical therapy, or other services not performed by a physician are supported by certification of the attending physician that such supplies, equipment or services are medically necessary.

It is your responsibility to accumulate your bills, receipts, and other supporting documents for a claim. By planning ahead, you can help yourself to obtain all the benefits to which you are entitled with a minimum of time and effort.

If you are in doubt as to whether you should file a claim, you are urged to submit a claim and allow the insurance carrier to determine benefits which might be payable.

## Subrogation

In the event any payment for benefits is made by a Health Care carrier under the GM Insurance Program for services which are legally determined to be payable by a third party, such carrier shall acquire all of the employee's or dependent's rights of recovery as a result of a settlement or judgment brought against any person or organization, except against insurers on policies issued in the name of the employee or dependent.

## Certificates

The foregoing is intended only as an outline of your GM Health Care coverages. Actual governing provisions and specific exclusions are contained in the applicable benefit certificates and any riders thereto or similar documents provided by the carriers. Certificates will be made available to you upon request from the insurance office at your GM location or from your local Blue Cross or Blue Shield plan, Metropolitan Life, or Connecticut General, as may be applicable.

## EXPLANATION OF CERTAIN TERMS APPLICABLE TO HEALTH CARE COVERAGES

### Carrier . . .

any entity through which benefits are paid or coverage is underwritten, such as a Blue Cross plan, or a commercial insurance company.

### Approved Facility or Treatment Program . . .

a facility or a treatment program that has met criteria established by the local carrier to provide certain services covered by the GM Insurance Program. The following are examples of facilities or treatment programs which must be approved in order for benefits to be paid:

- hospitals
- nursing homes

- outpatient psychiatric care facilities
- substance abuse treatment facilities
- outlets for prosthetic appliances
- free-standing physical therapy facilities
- home care programs

If you are not sure as to the approved status of a facility or treatment program, you may seek advice from the insurance office at your GM location or request information from your local carrier.

## Copayment

a part of the charge for services which you must pay. Most health care expenses are paid in full by the appropriate carrier. However, you must pay part of the charge or a "copayment" for certain services such as outpatient psychiatric care, prescription drugs, dental care and vision care.

## Participating Provider . . .

a person (such as a doctor) or a facility (such as a hospital) that provides health care services. Providers are considered to be "participating" when they have signed an agreement with the carrier to accept as payment in full whatever the carrier determines to be an appropriate charge for services rendered.

You may be uncertain about the participating status, or whether there is any need for participation by any health care provider in your local plan area. If in doubt, contact your local carrier or the insurance office at your GM location.

## Reasonable and Customary Charge . . .

an amount determined by the carrier—it is the usual amount charged by providers for a specific service in a geographic area.

## WHEN YOU RETIRE

### YOUR GM RETIREMENT PROGRAM IS MADE UP OF TWO PARTS

#### Part A . . .

is non-contributory. General Motors pays the entire cost. Benefits provided under Part A of the Program are comparable to those provided under the Hourly Pension Plan. This assures salaried employees that they will receive monthly retirement benefits at least equal to those provided to hourly employees. Part A provides monthly benefits for all employees who have 10 or more years of credited service who retire under the Program, or leave General Motors before age 70. There is no 10 year minimum credited service requirement if you retire at age 70. Part A consists of:

- basic benefits;
- temporary benefits; and
- supplements.

#### Part B . . .

is contributory. To receive full Part B benefits, you must contribute at all times while eligible and leave your contributions in the Program until retirement. Part B provides you with an opportunity to build up substantial additional monthly benefits, consisting of:

- supplementary benefits, which are based on your years of credited service, your average monthly base salary over the highest 60 months during the 120 months immediately preceding retirement, or age 65 if earlier, and
- primary benefits, which are based on the amount you contribute.

While you must contribute to participate in Part B of the Program, General Motors pays the entire cost of sup-

plementary benefits, and most of the cost of primary benefits.

### YOU ARE ELIGIBLE TO PARTICIPATE . . .

in Part A automatically when you become a GM salaried employee.

You are eligible to contribute under Part B when you have:

- attained age 25, and
- have 6 months of continuous service.

Your Part B contribution is 2% of monthly base salary in excess of \$1,000. When you elect to participate in Part B, your contribution is deducted from your salary each month.

### YOU ARE ELIGIBLE TO RETIRE . . .

under normal retirement provisions when you attain age 65. Retirement is automatic at age 70.

You may retire at any age if you have 30 or more years of credited service.

If you have 10 or more years of credited service, you may retire:

- as early as age 55, or
- at any age in case of total and permanent disability.

### CREDITED SERVICE

Your credited service is used in determining your Part A benefits and any Part B supplementary benefit.

Before October 1, 1950 . . .

your credited service includes all periods of employment with General Motors, and certain periods of absence as explained in the Program.

After October 1, 1950 . . .

your credited service includes all periods of employment for which you are paid.

If you are on an approved military leave, or on a disability leave and receive workers compensation, you may receive credited service for such absence.

If you were on layoff at any time during 1951 through 1967, upon application you may receive credited service for all or part of such absence. The amount of credited service you will receive will depend on your years of credited service as of December 31, 1967, December 31, 1973, or October 1, 1979, as may be applicable.

Commencing with the calendar year 1968, you are eligible for credited service for each calendar month of disability leave or layoff in a year during which you receive pay for periods totaling at least one month. After 1970, up to eleven months may be credited for a disability leave or layoff which continues into the following year.

If you were on a special leave of absence because of pregnancy between October 1, 1950 and before January 1, 1968, upon application you may receive four months credited service for each such absence.

After age 65, credited service will accrue only until you acquire 10 years of credited service.

#### Foundry/Asbestos Service

An employe with credited service on or after October 1, 1979 who at retirement has more than 10 years of credited service accrued in certain salaried positions in foundry or asbestos operations at designated GM locations will receive additional credited service.

#### Annual Statement

Each year you will be given a statement showing your total credited service and contributions up to the end of the preceding calendar year.

If you have any question concerning the correctness of your statement, contact your personnel department.

#### Loss of Credited Service

You will lose all credited service under the Retirement Program if you quit, are discharged, or are separated for any other reason. However, if you are reemployed by General Motors, your credited service may be reinstated upon proper application. If you have prior credited service which has not been reinstated, you should make application for its reinstatement. Application forms are available at the personnel department.

#### ALTERNATIVE "SERVICE" TO DETERMINE VESTED BENEFIT

If you lose credited service before age 70 and have less than 10 years of credited service but have 10 years of "service" as determined below, you would be eligible for a vested Part A basic benefit. For example, if you have only 8 years of credited service but have 10 years of "service", the 10 years' "service" would provide you a vested Part A basic benefit. The monthly amount of the benefit would be based on 8 years of credited service, however.

You first become eligible to be covered for the "service" provision when you attain age 25, or complete 1 year of "service", whichever is later. You get 1 year of "service" when you complete 750 hours of "service" in a 12 consecutive month period, beginning with your employment date. You complete an hour of "service" for each hour for which you are paid by General Motors for working or for having been entitled to work. No "service" is granted for any period of employment prior to age 22, or for any year in which you are paid by General Motors for working fewer than 750 hours.

A 1-year break in "service" will occur if you do not complete 375 hours of "service" in any 12 consecutive month

period. Hours paid for vacation and sickness or disability, which are not worked, may be counted to prevent a break in "service". You will lose your years of "service" if the number of consecutive 1-year breaks equals or exceeds the years of "service" before such break.

### RETIREMENT AT AGE 62 OR LATER

If you retire at or after age 62, you may receive the following benefits:

#### Part A Basic Benefit

Your monthly Part A basic benefit is determined by your basic benefit rate times your years of credited service.

Your basic benefit rate depends on your benefit class code (which is based on the maximum monthly base salary rate for your salaried position) and your retirement date, as follows:

Retirement Date and Monthly Basic Benefit Rate Per Year  
of Credited Service

Benefit Class Code	10-1-79 through 1-1-80	2-1-80 through 7-1-80	8-1-80 through 9-1-80	10-1-80 through 1-1-81	2-1-81 through 7-1-81	8-1-81 through 9-1-81	10-1-81 through 1-1-82	2-1-82 through 7-1-82	8-1-82 and after
A	\$ 15.75	\$ 15.95	\$ 16.20	\$ 16.55	\$ 16.85	\$ 17.15	\$ 17.55	\$ 17.85	\$ 18.20
B	16.00	16.20	16.45	16.80	17.10	17.40	17.80	18.10	18.45
C	16.25	16.45	16.70	17.05	17.35	17.65	18.05	18.35	18.70
D	16.50	16.70	16.95	17.30	17.60	17.90	18.30	18.60	18.95

Most salaried employees have the "D" benefit class code. For example, if you retire October 1, 1981, at age 65 with a basic benefit rate of \$18.30 and have 30 years of credited service, your monthly Part A basic benefit will be \$549.00 ( $\$18.30 \times 30 = \$549.00$ ).

#### After-Retirement Increases In Part A Basic Benefit

Your monthly Part A basic benefit rate will be increased periodically after your retirement. The dates and amounts of these increases are shown in the following table:

Date and Amount of Increase in Monthly Basic Benefit Rate Per Year of Credited Service							
2-1-80	8-1-80	10-1-80	2-1-81	8-1-81	10-1-81	2-1-82	8-1-82
\$	\$	\$	\$	\$	\$	\$	\$
0.20	0.25	0.25	0.30	0.30	0.30	0.30	0.35

#### Special Benefit

In addition, at age 65, or earlier if you are enrolled for Part B of Medicare under Social Security, you will receive a monthly special benefit as described on pages 17 and 18.

#### Part B Primary Benefit

Your Part B primary benefit will be based on your contributions in the Program. This monthly benefit will equal 5% of your contributions made before July 1, 1977, plus  $6\frac{1}{4}\%$  of your contributions made between July 1, 1977, and October 1, 1979, plus  $8\frac{1}{3}\%$  of your contributions made thereafter.

For example, if you retire October 1, 1981, and you had contributed \$8,800 before July 1, 1977, \$900 between July 1, 1977, and October 1, 1979, and \$700 through September 30, 1981, your monthly Part B primary benefit would be:

$$\$8,800 \times 5\% = \$440.00$$

$$\$900 \times 6\frac{1}{4}\% = 56.25$$

$$\$700 \times 8\frac{1}{3}\% = 58.31$$

Monthly Part B

Primary Benefit \$554.56

No Part B contributions will be permitted under the program after the first day of the month coinciding with or next following your 65th birthday.

#### Part B Supplementary Benefit

You also may receive a monthly Part B supplementary benefit. This benefit will equal 1% of the amount by which your average monthly base salary exceeds the applicable amount shown in the following table, multiplied by your years of credited service. Average monthly base salary is calculated over the highest 60 months during the 120 months preceding the earlier of age 65 or date of retirement.

Retirement Date	Applicable Amount
10-1-79 through 1-1-80	1,650
2-1-80 through 7-1-80	1,670
8-1-80 through 9-1-80	1,695
10-1-80 through 1-1-81	1,730
2-1-81 through 7-1-81	1,760
8-1-81 through 9-1-81	1,790
10-1-81 through 1-1-82	1,830
2-1-82 through 7-1-82	1,860
8-1-82 and after	1,895

For example, if you retire October 1, 1981, at age 65 with an average monthly base salary of \$2,100 and have

30 years of credited service, your monthly Part B supplementary benefit would be \$81.00.

60 Month Average Base Salary .....	\$2,100.00
Less Applicable Amount .....	1,830.00
	<u>\$ 270.00</u>

Times Part B Supplementary Benefit Rate .....	× 1%
	<u>\$ 2.70</u>

Times Years of Credited Service .....	× 30
---------------------------------------	------

Equals Monthly Part B Supplementary Benefit .....	<u>\$ 81.00</u>
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Summarizing the examples shown for an employee retiring October 1, 1981, at age 65 with 30 years of credited service, the total monthly benefits at retirement would be:

Part A Basic Benefit .....	\$549.00
Part B Primary Benefit .....	554.56
Part B Supplementary Benefit .....	81.00
Special Benefit .....	9.70
Total Monthly Benefit .....	<u>\$1194.26</u>

#### RETIREMENT PRIOR TO AGE 62 WITH UNREDUCED BENEFITS

Your benefits will not be reduced if you have 10 or more years of credited service and you retire prior to age 62 under one of the following types of retirement:

- Mutually Satisfactory Retirement—as early as age 60. Retirement must be agreeable to you and General Motors.
- Special Early Retirement—as early as age 55 and prior to age 60. Retirement must be initiated by General Motors and must be agreeable to you.
- Corporation Option Retirement—as early as age 55. If retirement is before age 60, it is subject to certain con-

ditions and approval by the applicable Corporation Committee.

- Disability Retirement—at any age. Retirement can commence after you are disabled for at least 5 months.

#### Part A Basic Benefit

For any of the preceding types of retirement, your monthly Part A basic benefit, as shown on page 13, will be determined as if you had retired at age 62, but based on your credited service at the time you retire.

#### Part A Temporary Benefit

In addition, you may receive a monthly Part A temporary benefit until you reach age 62, or if earlier, until you become eligible for Social Security disability insurance benefits.

The amount of your monthly temporary benefit will be based on your years of credited service, up to 25, and your retirement date, as follows:

Retirement Date	Monthly Temporary Benefit	
	Per Year of Credited Service	Maximum
	\$	\$
10-1-79 through 9-1-80	13.00	325.00
10-1-80 through 9-1-81	14.00	350.00
10-1-81 and after	15.00	375.00

If you retire because of total and permanent disability, the temporary benefit will be paid only if you submit evidence that you are not eligible for Social Security disability insurance benefits.

### Part A Supplements

You also may receive a monthly Part A early retirement supplement. This supplement is reduced by any monthly Part B supplementary benefit payable to you. This supplement is described on page 16.

### Special Benefit

In addition, at age 65, or earlier if you are enrolled for Part B of Medicare under Social Security, you will receive a monthly special benefit as described on pages 17 and 18.

### Part B Primary Benefit

If you have contributions in the Program, you also will receive a monthly Part B primary benefit, determined as if you had retired at age 62, but based upon the actual amount of contributions you made. An example of this benefit is shown on page 14.

### Part B Supplementary Benefit

Any monthly Part B supplementary benefit will be based on your average monthly base salary over the highest 60 months during the 120 months immediately preceding retirement and credited service at the time you retire. An example of this benefit is shown on page 14.

### RETIREMENT PRIOR TO AGE 62 WITH REDUCED BENEFITS

You may retire voluntarily with reduced benefits:

- at any age if you have 30 or more years of credited service, or
- as early as age 55 and prior to age 62 if you have 10 or more years of credited service.

### Part A Basic Benefit

Your monthly Part A basic benefit as shown on page 13 will be determined as if you had retired at age 62, but based on your credited service at the time you retire.

This benefit then will be reduced based on your age at retirement if you elect to have it commence before you attain age 62. However, if you have 30 or more years of credited service or your years of age and credited service total 85 or more, such reduction will apply only until you attain age 62.

### Part A Supplements

You also may receive a monthly Part A "early retirement", or an "interim" supplement. These supplements are reduced by any monthly Part B supplementary benefit payable to you. Part A supplements are described on pages 16 and 17.

### Special Benefit

In addition, at age 65, or earlier if you are enrolled for Part B of Medicare under Social Security, you will receive a monthly special benefit as described on pages 17 and 18.

### Part B Benefits

Any monthly Part B primary and supplementary benefits, as described on page 14, will be determined just as for other types of retirement. Monthly Part B benefits will be reduced permanently, however, if you elect to have them commence prior to age 62.

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### Important Note

If you retire voluntarily as early as age 55 and prior to age 60, and your combined years of age and credited service total less than 85, other GM benefit programs as well as your benefits under the Retirement Program will be affected. For example:

- You will forfeit unearned GM contributions under the Savings-Stock Purchase Program,
  - You must pay the full cost of any insurance coverages you may wish to continue, and
  - Your retirement benefits will be further reduced.
-

## PART A SUPPLEMENTS FOR RETIREMENT WITH 30 OR MORE YEARS OF SERVICE

### An "Early Retirement Supplement" . . .

may be payable to you each month if you retire before age 62 with 30 or more years of credited service. This supplement is an amount which, when added to the sum of all other Part A and any Part B supplementary benefits payable to you, prior to reduction for any survivor option, will raise the total of these benefits, payable prior to your attaining age 62, to the amount shown in the following table:

Retirement Date and Total Monthly Benefit Amount for Determining Early Retirement Supplement Prior to Age 62							
10-1-79 through 1-1-80	2-1-80 through 7-1-80	8-1-80 through 9-1-80	10-1-80 through 1-1-81	2-1-81 through 7-1-81	8-1-81 through 9-1-81	10-1-81 through 1-1-82	2-1-82 through 7-1-82 and after
\$ 800	\$ 810	\$ 825	\$ 845	\$ 860	\$ 875	\$ 895	\$ 915
							\$ 935

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### After Retirement Increases in Total Monthly Benefit Amount

Your total monthly benefit amount will be increased periodically after your retirement. The dates and amounts of these increases are shown in the following table:

Date and Amount of Increase in Total Monthly Benefit Amount							
Retirement Date	2-1-80	8-1-80	10-1-80	2-1-81	8-1-81	10-1-81	2-1-82 8-1-82
10-1-79/9-1-80	\$ 10	\$ 15	\$ 15	\$ 15	\$ 15	\$ 15	\$ 15
10-1-80/9-1-81	—	—	—	15	15	15	20
10-1-81 and after	—	—	—	—	—	—	20

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## PART A SUPPLEMENTS FOR RETIREMENT WITH LESS THAN 30 YEARS OF SERVICE

An "Interim" Supplement. . .

may be payable to you each month until you attain age 62 if you retire *voluntarily* before age 62 with less than 30 years of credited service. If you retire as early as age 55 and prior to 60, your age plus credited service must total 85 or more to be eligible for this supplement. The table to the right shows the amount of this supplement, which is based on your age at retirement. The amount of this supplement is reduced by the amount of any monthly Part B supplementary benefit payable to you prior to reduction for any survivor option.

Age at Retirement	Monthly Amount of "Interim" Supplement Per Year of Credited Service		
	10-1-79	10-1-80	10-1-81
	\$	\$	\$
55	4.75	5.00	5.25
56	5.75	6.00	6.25
57	7.00	7.25	7.50
58	8.25	8.50	8.75
59	9.00	9.50	10.00
60	10.50	11.00	11.50
61	10.50	11.00	11.50

*Note: Amounts are prorated for intermediate ages.*

## PART A SUPPLEMENTS—LIMITATIONS

- Supplements are not payable to you if you retire *voluntarily* as early as age 55 and prior to age 60 and the sum of your age and years of credited service is less than 85, or if you are discharged.
- If your total monthly Part A and Part B supplementary benefits at retirement prior to age 62 would be more than 70% of your final monthly base salary plus cost of living allowance, any supplement will be reduced by the amount over 70%.

- If you retire voluntarily and become eligible for a Social Security disability insurance benefit, your supplement will be reduced by the temporary benefit in effect at the time of your Social Security disability insurance benefit award.
- If, after retirement, you earn more in a calendar year than the following amounts, any supplement payable prior to age 62 will be reduced by \$2 for each \$1 of your excess earnings:

Calendar Year	Annual Earnings Limitation Amount
	\$
1980	4,500
1981	5,000
1982	5,500

## WORKERS COMPENSATION OFFSET

Workers compensation benefits paid to retired employees will be deducted from GM retirement benefits otherwise payable, unless such workers compensation payments are paid under a claim filed not later than two years after the employee lost credited service.

## SPECIAL BENEFIT

Each retired employee and surviving spouse who is age 65 or older and receiving a GM monthly Part A retirement benefit or a retirement survivor benefit will receive an additional monthly benefit amount, provided under the Insurance Program, but included in the monthly retirement check, as follows:

10-1-79 through 9-1-80	10-1-80 through 9-1-81	10-1-81 and after
\$	\$	\$
8.70	9.20	9.70

This benefit also is payable upon application to a retiree or surviving spouse receiving GM monthly Part A retirement benefits who is under age 65 and enrolled in Part B of Medicare. It is not payable to former employees receiving deferred vested retirement benefits or to the surviving spouses of such former employees. Not more than one such special benefit is payable to any individual for any one month.

### SURVIVOR BENEFITS

In the event of your death, either before or after you retire, monthly benefits may be provided for the lifetime of your survivor.

Refer to pages 38, 39 and 40 for an explanation of these important benefits, including the optional pre-retirement surviving spouse benefit available at no cost to you if you contribute under Part B of the Program.

### SOCIAL SECURITY BENEFITS...

are in addition to your GM retirement benefits. You and General Motors contribute equally to the cost of Social Security benefits. Your share of the cost is deducted from your pay. Social Security old age benefits may begin as early as age 62 in a permanently reduced amount. Benefits are payable in full if they begin at or after age 65.

Social Security disability insurance benefits may begin at any age.

Your spouse's Social Security benefit at age 65 will be equal to one-half of your unreduced Social Security benefit, unless your spouse is eligible for a higher benefit based on his or her own earnings. Your spouse may receive a permanently reduced benefit as early as age 62, or age 60 if a widow or a widower.

The following table may help you estimate your monthly Social Security benefit. The table is based on the Social Security provisions in effect on January 1, 1980:

### ESTIMATED MONTHLY SOCIAL SECURITY OLD AGE BENEFITS FOR RETIREMENT IN 1980

And Social Security Commences When You and Your Spouse Are

If You Retire At Age	Age 65		Age 62	
	Retiree	Spouse	Retiree	Spouse
	Total		Total	
65	\$ 570	\$ 285	\$ 855	\$ —
62	503	251	754	189
60	491	245	736	184
55	460	230	690	172
				591
				577
				540

NOTE: Amounts are rounded to nearest dollar. In all instances, you and your spouse are assumed to be the same age. You and your spouse may receive lower benefits from Social Security than those shown above if you earned less than the maximum amount subject to Social Security taxes. These amounts are based on assumptions which were reasonable at the time estimates were made. Because Social Security benefits actually payable reflect individual and national average earnings as well as fluctuations in the consumer price index, you may wish to obtain an estimate based on your personal earnings history from your local Social Security office before retiring.

## EXAMPLES—RETIREMENT AT AGE 65

Assume you have participated fully in Part B of the Program and retire June 1, 1980 at age 65 with 30 years of credited service.

### YOUR COMBINED MONTHLY GM AND SOCIAL SECURITY BENEFITS ESTIMATED FOR RETIREMENT ON JUNE 1, 1980

Contributions to age 65	Assumed Average Monthly Base Salary Highest 60 of 120 Months Before Retirement	Monthly Benefit Amounts					Total
		Part B			Social Security (Maximum)		
		Part A	Primary	Supplementary	Self	Spouse	
\$ 8,400	\$ 1,800	\$ 501	\$ 335	\$ 39	\$ 570	\$ 285	\$ 1,730
9,930	2,100	501	516	129	570	285	2,001
10,650	2,400	501	554	219	570	285	2,129
11,340	2,700	501	590	309	570	285	2,255

**NOTE:** Amounts are rounded to the nearest dollar. Increases in both Part A and Part B benefits which are scheduled to become effective subsequent to June 1, 1980 would be added to the amounts shown in all cases. You and your spouse are assumed to be the same age. You and your spouse may receive lower benefits from Social Security than the estimated amounts shown above if you earned less than the maximum amount subject to Social Security taxes.

## MORE INFORMATION ABOUT YOUR RETIREMENT BENEFITS

Additional information about Salaried Retirement Program benefits appears elsewhere in this booklet under applicable headings. For more information about your retirement, you should contact your personnel department.

## OTHER BENEFIT PROGRAM COVERAGES— AFTER RETIREMENT

### Savings-Stock Purchase Program

You may receive a lump sum distribution of your account, including full earn-out of GM contributions (except for voluntary retirement as early as age 55 and prior to age 60 when your combined years of age and credited service total less than 85—in which case you will receive earned-out GM contributions).

**Deferral of Distribution**—If you retire during a year in which you will not reach or exceed age 65, you may defer the receipt of your account until the next year.

**Lifetime Annuity Contract**—In lieu of receiving your account in a lump sum at retirement or deferring receipt of your account, you may elect to convert all or part of your eligible assets to an annuity which will provide a monthly income after retirement. The conversion would be made through an insurance carrier selected by General Motors, at favorable group rates.

**Individual Retirement Account**—Another alternative available at retirement, outside the Savings-Stock Purchase Program, is the conversion or “roll over” of certain assets to an individual Retirement Account (IRA). Simliar to the Annuity Option, an IRA will provide for deferred income. The “roll over” of assets is arranged between you and a bank or investment company of your choice.

Refer to page 21 for additional information on the Savings-Stock Purchase Program.

### Employee Stock Ownership Plan

You will receive two distributions of your account following your retirement. The first distribution will be in February following the year of retirement. It will consist of your entire balance at that time. In February of the second year following the year of termination, the amount allocated to your account for the year in which you retired will be distributed. Refer to page 25 for additional information about the Employee Stock Ownership Plan.

### Health Care Coverages

Your basic Health Care coverages (except vision prior to October 1, 1980) will be provided at GM expense for your lifetime (except for voluntary retirement as early as age 55 and prior to age 60 when combined years of age and credited service total less than 85, or for retirement as early as age 60 and prior to 65 without retirement benefits).

If you retire voluntarily as early as age 55 and prior to age 60 when your combined years of age and credited service total less than 85, or retire as early as age 60 and prior to 65 without retirement benefits, you may continue your basic Health Care coverages for your lifetime provided you pay the full monthly cost.

During periods that basic coverages are in effect, you also may continue your comprehensive medical expense insurance coverage by making the monthly contributions applicable to retirees (see page 6) or by paying the full monthly cost if applicable.

### Life Insurance

Your basic life, extra accident, and survivor income benefit insurance will be continued at GM's expense until age 65 (except for voluntary retirement as early as age 55 and prior to age 60 when your combined years of age and

credited service total less than 85). At age 65, extra accident and survivor income benefit insurance ceases.

If you retire voluntarily as early as age 55 and prior to age 60 when your combined years of age and credited service total less than 85, you may continue your basic life, extra accident, and survivor income benefit insurance to age 65, provided you pay 50 cents per month for each \$1,000 of basic life insurance in force.

Refer to page 36 for an explanation of continuing life insurance protection after age 65.

If you have at least 5 years of participation at age 60 and cease active work for any reason, you may continue basic life, extra accident, and survivor income benefit insurance to the end of the month in which you attain age 65. If you are eligible for retirement benefits, General Motors will pay the full cost of such insurance. If you are not eligible for retirement benefits, you must contribute 50 cents per month for each \$1,000 of basic life insurance in force.

Optional and dependent group life insurance may be continued to age 70 provided that your basic life insurance remains in force and you pay the required monthly contributions. See page 37 for further explanation of these coverages after age 65.

### Personal Accident Insurance

You may continue this insurance on yourself and any eligible dependents for your lifetime, by paying the required premiums. However, after you are age 70, insurance in force on each person insured may not exceed \$50,000.

## SAVING WITH GENERAL MOTORS

### UNDER THE GM SAVINGS-STOCK PURCHASE PROGRAM

The purpose of the Savings-Stock Purchase Program is to help you accumulate savings and to provide you an opportunity to acquire a stock interest in General Motors.

#### You Are Eligible . . .

to participate in the Program if you have at least 6 months of continuous employment. You may withdraw from the Program at any time.

#### How the Program Works

You may save up to 15% of your eligible salary (base salary plus cost of living allowance, if any) each month through payroll deductions or cash contributions. General Motors contributes one dollar for each dollar you save up to 5% of your eligible salary. General Motors will contribute 60 cents for each dollar you save from 5% to 10% of your eligible salary. Your savings above 10% of your eligible salary will not be matched by GM contributions. All funds are turned over to a trustee for investment in securities.

Of the amount you save up to 10% of your eligible salary, one-half must be invested in GM common stock. All of the rest of your savings will be invested in one of five available investment options described later. All of the amount contributed by General Motors is invested in GM common stock.

The chart below illustrates how the Program works.

Dividends and other earnings on all these assets are re-invested under your account as received.

For Each \$1 of Eligible Salary You Save	Amount of Your Savings Invested In		GM Contribution Invested In GM Common Stock
	GM Common Stock	Elected Option	
Up to 5%	\$ .50	\$ .50	\$1.00
From 5% to 10%	\$ .50	\$ .50	\$ .60
From 10% to 15%	—	\$1.00	—

#### Savings Are Accumulated in "Classes" . . .

which are formed each calendar year. You put your savings into a class only during the year in which it is formed.

At the end of the year, that class is closed to any further savings. On January 1 of the next year, a new class will be formed.

#### You Make an Investment Election . . .

requesting the trustee to invest one-half of your savings up to 10% of your eligible salary and all of your savings above 10% of your eligible salary in one of the following options:

- Investment Option #1—  
U.S. Savings Bonds

These bonds have specified redemption values.

- Investment Option #2—Diversified  
U.S. Government Securities

This is a portfolio of U.S. Government bonds, notes, and bills, and has a fluctuating value.

- Investment Option #3—100% GM Common Stock

This option allows you to invest your savings entirely in GM common stock.

- Investment Option #4—Income Fund

This is a fund managed by an insurance company which guarantees a specified minimum annual interest yield over a specified period of time.

- Investment Option #5—Equity Index Fund

This is a portfolio of common stocks which is managed by an investment company with the objective of matching the overall investment performance of the stock market.

You may change your investment election once each year. If you do not do so, your previous investment election will continue to apply to each subsequent class until you change it. Once you have made your election for a class, you may not change your election until the next year's class, however.

#### Class Maturity is Reached 3 Years . . .

after the end of the year of class formation. At that time the GM contributions in each class are completely earned-out or matured.

GM contributions are earned-out at the rate of  $8\frac{1}{3}\%$  for each complete calendar month beginning January 31 of the third year after the year of class formation. They are fully earned-out, or matured, on December 31 of the third year. For example, the 1980 class will commence to earn-out January 31, 1983 and will fully earn-out December 31, 1983.

GM contributions in unmatured classes are fully earned-out immediately under most types of retirement and for certain other terminations of employment. (See pages 19, 32, 40, and 43.)

#### You Make a Distribution Election . . .

which determines when you will receive the assets of a class. You may elect either to:

- leave your assets (other than the portion invested in U.S. Savings Bonds, if any) in that class until your retirement or other termination of employment, subject to withdrawal rights as described later,

— or —

- receive all assets in that class early in the year following maturity.

You may change your distribution election prior to the maturity of each class. If you do not do so, your previous distribution election will continue to apply to each subsequent class until you change it.

Any U.S. Savings Bonds to your credit will be distributed to you automatically upon maturity of the class, regardless of your distribution election.

#### You May Withdraw At Any Time If You Withdraw From a Class Before It Matures . . .

you will receive the assets representing your savings, any earned-out GM contributions, and any earnings to your credit in the class. You will not receive unearned GM contributions or earnings thereon.

Any withdrawal prior to class maturity must include all your savings in the class or classes withdrawn.

Withdrawals must be made first from all savings in the class being formed and then from all savings in one or more previous unmatured classes. Withdrawals are made from classes in the reverse sequence in which the classes were formed. For example, from the 1980 class first and then from the 1979 class, the 1978 class, and the 1977 class.

You may withdraw from an unmatured class once during any calendar year and continue to place savings in the current class. However, if you withdraw a second time during a calendar year, you will not be eligible to add savings for the remainder of the current class. In any event, you may not replace the amount withdrawn.

#### If You Withdraw From a Class After It Matures . . .

you may withdraw all or any part of your savings from the class without penalty.

After you withdraw all of your own savings in matured classes, you may withdraw assets attributable to GM contributions and earnings on all assets, subject to the following:

- A penalty of 6% of the market value of the assets withdrawn would be deducted from future GM contributions to your account. Under tax law a penalty such as this is necessary to permit withdrawals and still maintain favorable tax treatment of benefits under the Program.
- The amount of GM contributions and earnings withdrawn must total at least \$500. If the assets in your matured classes have a value of less than \$500, you will be required to withdraw all such assets.

#### A Guaranty Protects Your Savings Until the Class Matures

The market value of GM common stock can go down as well as up. You are protected by a guaranty against any

substantial downswing in market value of GM common stock until maturity of each class. No guaranty applies to your savings in excess of 10% of your eligible salary or your savings in matured classes.

#### For Classes Formed Prior to January 1, 1978

If you withdraw from your account or terminate your employment prior to maturity of a class, and if the current market value of all the GM common stock, U.S. Government securities and cash to your credit in that class at that time is less than the amount of your savings plus interest, you will be paid the difference in cash.

If, at maturity of a class, the current market value of all your assets in that class is less than the amount of your savings plus interest, you will be paid the difference in cash.

#### For Classes Formed On and After January 1, 1978

A new uniform guaranty will apply to the five investment options available for classes formed on and after January 1, 1978.

The uniform guaranty assures that the portion of your savings which is required to be invested in GM common stock will be returned with interest in an amount equal to that which is payable on U.S. Savings Bonds. Additionally, you will receive the full current value of the rest of your savings invested in the investment option of your choice, including all savings above 10% of your eligible salary, based on the actual performance of that investment option.

#### Voting Rights

You will be extended the right to vote, through the trustee, all shares (including fractional shares, whether or not those shares are earned-out) in your account in the trust on the record date for voting at each Annual Meeting of Stockholders.

You may exercise your right to vote by completing, signing and forwarding a voting instruction card to the trustee, who will vote by proxy with proper precautions to preserve the complete confidentiality of your vote.

#### How Assets Are Distributed

You will receive the Program assets to which you are entitled in the following form:

##### GM Common Stock

At class maturity stock certificates may be registered in your name alone, or in your name with one other individual as a "joint tenant with right of survivorship and not as tenants in common". Shares of stock will be delivered in kind.

In the event of your death, stock certificates will be registered in the name of the beneficiary(ies) you have designated.

In the case of a withdrawal from a class prior to, or subsequent to, its maturity, or upon receipt of a settlement at termination of employment, you may elect to receive stock certificates registered in your name alone, or cash value in lieu of the actual shares of stock.

##### Other Assets

U.S. Savings Bonds will be registered in your name, or you may elect to receive the cash value in lieu of the actual bonds.

Units to your credit in Diversified U.S. Government securities, the Income Fund or Equity Index Fund always will be settled in cash. The amount of cash will be based on the current value of the units.

#### Designation of Beneficiaries

You will be asked to complete a written designation of beneficiary or beneficiaries. This may be changed by you at any time.

Your beneficiary or beneficiaries will receive, in the event of your death, all or part of the assets in your account in accordance with your designation. Assets in your account not affected by your designation, or all of the assets in your account in the absence of such a designation, will be distributed to your estate.

#### Annual Statement and Tax Information

You will be furnished an annual statement showing the amount of assets to your credit under the Program.

Tax information will be furnished to you from time to time during your participation in the Program—for example, when you make a distribution election, and for most types of distributions of assets.

## STOCK OWNERSHIP IN GENERAL MOTORS

### UNDER THE GM EMPLOYEE STOCK OWNERSHIP PLAN

The purpose of the General Motors Employee Stock Ownership Plan for Salaried Employees is to provide eligible salaried employees a stock interest in General Motors.

The Plan is funded by GM contributions equal to the additional investment tax credit provided under the Internal Revenue Code for funding such plans. An eligible employee may contribute voluntarily to the Plan and thereby qualify for additional GM contributions matching the amount of such employee contributions. Contributions to the Plan may continue to be made only so long as, and to the extent that, the additional tax credit is available under the tax law.

#### You Are Eligible . . .

to participate in the Plan if you are a regular classified salaried employee on the first day of the calendar year following completion of 2 years of service and are or will be at least age 24 during the year in which you complete the second year of service. You will be enrolled automatically in the Plan.

#### The Plan Provides . . .

that for any year in which General Motors elects to claim the investment tax credit currently available under tax law for funding employee stock ownership plans, General Motors will contribute to GM employee stock ownership plans an amount equal to the tax credit for that year. This contribution will include an amount equal to the total amount contributed voluntarily to the plans by employees, up to the maximum permitted by tax law. All of GM's contribution and all amounts contributed by

employees will be invested in GM common stock. Shares of stock, including any fractional shares, will be allocated to the accounts of employees as soon as practicable. All assets allocated to an employee's account are retained by the trustee until the employee's retirement or other termination of employment.

There are two types of GM contributions to the Plan:

- The GM Automatic Contribution

General Motors automatically will contribute a specified amount to the Plan for a plan year as permitted under tax law. You will receive from this contribution an automatic allocation to your plan account.

- The GM Matching Contribution

In addition to the GM automatic contribution to the Plan, General Motors also will contribute an amount which matches the total voluntary contributions of all eligible employees. You must contribute to the Plan in order to receive from the GM matching contribution an allocation to your plan account. Your contribution is used to purchase GM common stock and will be matched dollar-for-dollar with an allocation of GM common stock purchased with the GM matching contribution.

#### The Amount of Your Automatic Allocation . . .

for any year is determined, in part, by the amount of the total automatic contribution General Motors is permitted to make to the Plan under the tax law. The amount of your automatic allocation also is determined by the relationship of your GM compensation to the total GM compensation of all eligible employees for that year. Compensation in excess of \$35,000 per year is disregarded for allocation purposes under the Plan.

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For example, if your eligible compensation for a year is \$20,000 and the automatic allocation for the year is \$2.00 worth of GM common stock for each \$1,000 of eligible compensation, you would receive \$40 worth of GM common stock for that year.

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#### The Amount of Your Matching Allocation . . .

for any year is determined by the amount, if any, which you actually contribute to the Plan. Your contribution will be matched dollar-for-dollar with an allocation from the GM matching contribution to the Plan.

#### Your Contributions . . .

to the Plan, if any, are voluntary. As an eligible employee, you will receive an automatic allocation of shares of GM common stock under the Plan whether or not you contribute to the Plan. However, by electing to contribute, you have the opportunity to increase your acquisition of shares for any year in which you do contribute.

The smallest amount you may contribute in any year is called your Minimum Matching Amount. This is your prorated portion of the maximum amount which General Motors is permitted to contribute to the Plan for matching purposes under the tax law.

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For example, if your eligible compensation for a year is \$20,000 and the Minimum Matching Amount for the year is \$1.00 worth of GM common stock for each \$1,000 of eligible compensation, you could contribute \$20 to the Plan and receive an additional \$40 worth of GM common stock for that year (your \$20 matched with GM's \$20).

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It may be possible for you to contribute more than your Minimum Matching Amount in a year. If you wish to contribute an additional amount, you may declare your desire to contribute 2, 3, 4 or 5 times your Minimum Matching Amount on the form provided to you. However, you will have the opportunity to make such additional contributions only to the extent that some employees decide *not* to contribute to the Plan.

The Minimum Matching Amounts of any employees who choose not to contribute to the Plan will be allocated among those eligible employees who wish to contribute additional amounts. In this allocation, all employee contributions of 2 times the Minimum Matching Amount will be accommodated before any contributions of 3 times such amount, and so on in this manner, until the total amount of the available GM matching contribution has been allocated among all employees who elect to contribute additional amounts.

Therefore, the actual amount which you are permitted to contribute to the Plan may be less than the amount you elect to contribute.

As soon as practicable after you submit your completed contribution election form, you will receive a statement from General Motors indicating the amount you will be permitted to contribute for the plan year. Your contribution then would be made by means of payroll deductions.

#### To illustrate . . .

how the Plan works, the chart which follows shows some typical annual automatic and matching allocations at various levels of annual earnings. For purposes of these examples, an employee contribution of the Minimum Matching Amount is assumed.

Your Assets Under the GM Automatic Contribution	Your Assets Under the GM Matching Contribution *		Your Annual Total Assets If You Contribute *
	Your Contribution at a Minimum Matching Amount of \$1 per \$1,000	Matching Allocation	
Your GM Earnings	Automatic Allocation at \$2 per \$1,000		
\$ 15,000	\$ 30	\$ 15	\$ 60
20,000	40	20	80
25,000	50	25	100
30,000	60	30	120
35,000	70	35	140

\* If you should elect *not* to contribute, this column would not apply to you. Keep in mind that contributions of up to 5 times your Minimum Matching Amount may be possible if sufficient GM matching contribution amounts are available.

### Dividends

Dividends paid on GM common stock held for you by the trustee will be invested in GM common stock and allocated to your account. Additional shares acquired through dividends will be allocated to your account as soon as practicable.

### Nonforfeitability

All shares (including fractional shares) of GM common stock allocated to your account will be nonforfeitable.

### Withdrawals

Withdrawals from the Plan are not permitted.

### Distribution

Distribution of your account is made after retirement or other termination of employment.

Generally, you will receive two distributions following your retirement or other termination of employment. The first distribution will be in February following the year of termination and will consist of your entire account balance at that time. In February of the second year following the year of termination, the amount allocated to your account for the year in which your employment terminates will be distributed to you.

Distribution will be made to you in shares of GM common stock. Any fractional share in your account will be paid to you in cash. In the event of your death, the distribution will be made to the beneficiary designated by you or, if you have not designated a beneficiary, to your estate.

### Voting Rights

You will be extended the right to vote, through the trustee, all shares (including fractional shares) allocated

to your account in the trust on the record date for voting at each Annual Meeting of Stockholders.

You may exercise your right to vote by completing, signing and forwarding a voting instruction card to the trustee, who will vote by proxy with proper precautions to preserve the complete confidentiality of your vote.

#### Designation of Beneficiaries

You will be asked to complete a written designation of beneficiary or beneficiaries. This may be changed by you at any time.

Your beneficiary or beneficiaries will receive, in the event of your death, all or part of the assets in your account in accordance with your designation. Assets in your account not affected by your designation, or all of the assets in your account in the absence of such a designation, will be distributed to your estate.

#### Annual Statement

Each year you will be furnished a statement showing the assets credited to your account.

### **WHILE YOU ARE DISABLED AND UNABLE TO WORK**

If you become disabled and are unable to work you may be approved for a disability leave of absence. To be granted a disability leave, you must furnish satisfactory medical evidence that you are unable to discharge your normal job responsibilities as a result of disability.

In the usual case, you will continue to receive your regular salary for the first week of your disability. Thereafter, while you remain disabled and furnish medical evidence satisfactory to General Motors and the insurance company, you may receive salary continuation and insured sickness and accident benefits, followed by extended disability benefits. Social Security disability insurance benefits also may become payable.

If you are totally and permanently disabled, monthly benefits also may be payable to you from the Group Insurance Program, the Retirement Program, and personal accident insurance. In addition, you may receive a distribution of your accounts, if any, under the Savings-Stock Purchase Program and Employee Stock Ownership Plan.

If you lose a bodily member or your eyesight through accidental means, additional benefits may be payable under your extra accident insurance and under personal accident insurance.

General Motors pays the full cost of your GM disability insurance (except personal accident) while you are at work or are on an approved disability leave of absence.

### **SICKNESS AND ACCIDENT BENEFITS**

#### **For Employees In Classified Salary Positions**

#### **You Are Covered . . .**

for sickness and accident benefit insurance on the first day of the fourth month following the month in which

you commence working with General Motors. If you are not at work on the date your insurance would otherwise start, coverage commences on the day you return to work.

#### While You Are Unable to Work . . .

because of sickness or injury and you are under the care of a doctor, sickness and accident benefits may be payable for as long as 12 months. Sickness and accident benefits also may be payable if you are disabled from surgery for sterilization, or if you are hospitalized for testing to determine suitability to be a donor for an organ or tissue transplant.

#### To Receive Sickness and Accident Benefits . . .

you must give written notice of any injury or sickness within 20 days after the accident causing your injury or the onset of sickness.

#### Sickness and Accident Benefits Begin . . .

after a 7-day waiting period (during which your salary may be continued).

#### Monthly Benefit Amounts . . .

are equal to 60% of your monthly base salary for periods of disability prior to the day you attain one year's length of service, and 75% thereafter, if you are otherwise eligible for sickness and accident benefits. Base salary, for this purpose, includes premium for necessary continuous 7-day operations but does not include overtime, night shift premium, or any cost of living allowance. Benefits are payable on your regular payday. These benefits are supplemented by salary continuation as shown in the table on page 31.

#### Duration of Benefits . . .

is based on your GM length of service or years of participation, if greater (see page 46).

For each month of service, you may receive one monthly benefit, up to a total of 12 monthly benefits.

If your GM service is less than 12 months, benefits nevertheless may continue for up to 12 months while you are hospitalized or while you are receiving workers compensation payments from General Motors.

If you return to work before the end of the maximum period for which you are eligible to receive sickness and accident benefits and are absent again because of the same or a related disability within three months, benefits pick up where they left off. If your second absence results from a different disability, the first absence does not affect the benefits or waiting period for the second absence.

#### Sickness and Accident Benefits Are Reduced By . . .

certain workers compensation or any unemployment compensation payments to which you are entitled for the same period that you receive sickness and accident benefits.

#### To Apply for Sickness and Accident Benefits . . .

you must complete a claim form provided by General Motors for that purpose and return it to your GM unit.

#### Employees In Unclassified Salaried Positions . . .

who become totally disabled may have all or part of their salary continued for up to 12 months while disabled, reduced by the amount of any Social Security disability insurance benefits received for the same period of disability.

### In Certain States . . .

employees in either classified or unclassified salaried positions may be eligible under a statutory disability benefits law for disability benefits for time lost from work. If you are an employee working in California, Hawaii, New Jersey, New York, Puerto Rico, or Rhode Island, certain modifications in your sickness and accident benefits or salary continuation payments during disability are explained in a special enclosed insert.

### EXTENDED DISABILITY BENEFITS

#### For Both Classified and Unclassified Employees

If you are still disabled after you receive sickness and accident benefits or salary continuation payments for the maximum period, or if you become disabled while on lay-off and are still disabled after you receive layoff benefits for the maximum period, you may be eligible to receive monthly extended disability benefits.

#### You Are Covered . . .

for extended disability benefit insurance on the first day of the fourth month following the month in which you commence working with General Motors.

#### To Receive Extended Disability Benefits . . .

you must be totally disabled so as to be unable to engage in any regular employment with General Motors at the location where you last worked, and must not be working elsewhere.

#### Monthly Benefit Amounts . . .

are equal to 60% of your monthly base salary. Base salary, for this purpose, includes premium for necessary continuous 7-day operations but does not include overtime, night shift premium, or any cost of living allowance.

### Duration of Benefits . . .

is based on your GM years of participation (see page 46).

- If you have 10 or more years of participation when you become disabled . . .

benefits are payable until recovery, but not beyond age 65.\*

- If you have less than 10 years of participation when you become disabled . . .

benefits are payable until recovery—or if less, for a period equal to your years of participation at the commencement of disability (less the period during which sickness and accident benefits or salary continuation payments are received), but not beyond age 65.\*

### Extended Disability Benefits Are Reduced By . . .

any Part A benefits and Part B supplementary benefits (see page 11) for which you may be eligible under the Retirement Program and any benefit for which you are eligible under a GM Pension Plan. In addition, governmental benefits such as workers compensation, certain Social Security benefits or any federal or state lost-time disability benefits are deductible. Increases in any of these benefits payable after extended disability benefits commence will not be deducted unless the increase represents an adjustment in the original determination of the amount of such benefit.

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\* However, effective January 1, 1979, if you should become disabled at or after age 63 and become eligible for extended disability benefits, benefits will be payable for up to 12 months, but not beyond age 70.

### A Monthly Special Benefit Equal To . . .

\$8.70 for months on or after October 1, 1979

\$9.20 for months on or after October 1, 1980

\$9.70 for months on or after October 1, 1981

will be payable to employees who are eligible to receive extended disability benefits, are not retired, and are enrolled in Medicare Part B.

### To Apply for Extended Disability Benefits . . .

you must complete a claim form provided by General Motors for that purpose and return it to your GM unit.

## ILLUSTRATION OF SALARY CONTINUATION, SICKNESS AND ACCIDENT BENEFITS (S&A) AND EXTENDED DISABILITY BENEFITS (EDB)

### TYPES OF DISABILITY PAYMENTS FOR PERIODS SHOWN BELOW

LENGTH OF SERVICE	Full salary *	S&A and salary combined equal to full salary *	Maximum S&A benefits payable **	Maximum EDB payable
LESS THAN 1 YEAR	1st week	—	Up to 12 months	None
1 YEAR TO 5 YEARS	1st week	next 7 weeks	12 months	For a period equal to years of partici- pation (if under 10) —less— the period S&A and/or salary continuation paid but not beyond age 65 ***
5 YEARS TO 10 YEARS	1st week	next 12 weeks	12 months	To age 65 *** (if years of participation are 10 or more)
10 OR MORE YEARS	1st week	next 25 weeks	12 months	

\* For this purpose, full salary includes base salary, cost of living allowance, and premium for necessary 7-day operations, but does not include overtime or night shift premium.

\*\* Employees in unclassified positions may have all or part of their salary continued for up to 12 months. They are not eligible for S&A.

\*\*\* Effective January 1, 1979, an employee disabled at or after age 63 who becomes eligible for extended disability benefits may receive benefits for up to 12 months, but not beyond age 70.

## TOTAL AND PERMANENT DISABILITY BENEFITS

### Monthly Instalment Payment of Your Basic Life Insurance . . .

may be elected if you have less than 10 years of participation and you become totally and permanently disabled before age 70 or the end of the month in which your length of service is broken, if earlier.

Monthly instalments, equal to the final monthly extended disability benefit amount payable, may commence after you have received your final monthly extended disability benefit.

Monthly payments will continue until the total amount paid equals the amount of your basic life insurance or \$100,000, if less. If the amount of your basic life insurance exceeds \$100,000, the excess will be canceled immediately prior to the commencement of the monthly payment and you will be entitled to convert the excess amount to an individual policy (see page 48).

Your designated beneficiary will be paid the remaining unpaid amount if you should die before you receive the full amount of your basic life insurance.

### To Apply for Instalment Payment of Your Life Insurance . . .

you must complete a claim form provided by General Motors for that purpose and return it to your GM unit.

### Your Basic Life, Extra Accident, and Survivor Income Benefit Insurance Will Be Continued . . .

at no cost to you while you are totally and permanently disabled prior to age 65 if you have 10 or more years of participation. At age 65, your extra accident and sur-

vivor income benefit insurance will be canceled and your basic life insurance will be reduced (see page 36).

### Unreduced Retirement Program Benefits May be Payable . . .

for the rest of your life if you are under age 65, with 10 or more years of credited service (see page 14).

### Savings-Stock Purchase Program and Employee Stock Ownership Plan Accounts May Be Distributed . . .

regardless of your age or the length of your GM service if you are participating in these plans. All assets in your accounts, including all GM contributions, may be distributed in lump sums.

### YOU MAY BE ASKED TO BE EXAMINED BY . . .

a doctor, clinic, or other medical authority for the purpose of verifying disability at any time you may be eligible to receive sickness and accident benefits, extended disability benefits or instalment payments of life insurance. Generally, if you are found able to work, your benefits will be discontinued. Failure to report for the examination may affect your eligibility for benefits. You will be reimbursed at 17¢ per mile for travel to and from the examination if your residence is 40 or more miles (one-way) from the examiner's office.

### SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

If you become disabled before age 65, you may be eligible for disability insurance benefits from Social Security. Your nearest Social Security office can tell you if you qualify. Benefits may be payable after you have been disabled for five full calendar months. However, you do not have to wait five months to apply.

The amount of Social Security benefits payable because of disability is generally in accord with the schedule set forth on page 18 for benefits payable at age 65.

## EXAMPLE OF GM DISABILITY INCOME BENEFITS

An employee age 37 earning a base salary of \$2,000 per month with 11 years of service who becomes totally and permanently disabled would receive:

- Salary continuation and sickness and accident benefits equal to \$2,000 per month plus cost of living allowance for the first 6 months.
- Monthly sickness and accident benefits of \$1,500 (75% of salary) for the next 6 months, followed by:
- Monthly extended disability benefits of \$1,200 (60% of salary) until age 65. This amount would include disability benefits from other sources such as Part A and Part B supplementary retirement benefits and Social Security disability insurance benefits. Any Part B primary retirement benefits would be in addition.
- Monthly total and permanent disability benefits payable for life under the Retirement Program.
- Entire account balance under the Savings-Stock Purchase Program and the Employee Stock Ownership Plan.

## ADDITIONAL INSURANCE BENEFITS— FOR ACCIDENTAL INJURY

### Your Extra Accident Insurance . . .

equal to one-half of your basic life insurance (as described on page 35), provides lump sum payments for bodily injuries (severance of a hand at or above the wrist joint or a foot, at or above the ankle joint, or the permanent loss of the sight of an eye) by accidental means if the loss occurs within two years of the accident. For any one of these losses, you may receive one-half of your extra accident insurance. Your full extra accident insurance may be paid to you if you should suffer two or more such losses. Extra accident insurance benefits are pay-

able whether you are injured on or off the job. The loss cannot be due to disease, self-inflicted injury or any act of war.

### If the Loss Occurs While You Are On Company Business . . .

an additional benefit may be paid equal to the amount of your extra accident insurance that is payable.

### To Apply for Extra Accident Insurance Benefits . . .

you must complete a claim form provided by General Motors for that purpose and return it to the GM unit where you last worked.

### Personal Accident Insurance . . .

also provides lump sum payments for loss of body members or eyesight as the result of an accident. Detailed information and enrollment cards are contained in the booklet, "Personal Accident Insurance".

## OTHER BENEFIT PROGRAM COVERAGES WHILE ON DISABILITY LEAVE

### Health Care Coverages

Your Health Care coverages (including dental) will continue to be provided at GM expense while you are on an approved disability leave and totally and continuously disabled. If you had less than six months of service when your leave commenced, you must share the cost.

You may continue your comprehensive medical expense insurance coverage by paying the usual monthly employee contribution for as long as your basic coverages remain in effect.

### Savings-Stock Purchase Program

You may continue regular monthly savings for up to one year while you are on an approved disability leave.

GM contributions continue to earn out while you are on disability leave.

#### Life and Disability Insurance

For any period during which you are entitled to receive sickness and accident benefits or salary continuation payments while you are totally disabled, basic life, extra accident, survivor income benefit, sickness and accident, and extended disability benefit insurance will be continued at no cost to you.

Thereafter, these coverages may be continued while you are totally and continuously disabled and remain on an approved disability leave of absence, but not to exceed the period equal to your years of participation (see page 46) as of the first day of disability. Also, such insurance may be continued while you are entitled to receive monthly extended disability benefits after cancellation of your disability leave because the period of such leave equaled your length of service. General Motors will pay the full cost of your insurance during these periods.

You must pay the required monthly contributions to continue optional and dependent group life insurance while your basic life insurance remains in force.

#### Personal Accident Insurance

You may continue this coverage on yourself and any eligible dependents for 12 to 24 months, depending on the method you use to pay premiums and the premium due date.

#### Retirement Program

You may continue to make regular monthly contributions to Part B for up to one year while on an approved disability leave.

You may continue to accrue credited service for up to 11 months while on an approved disability leave as explained on page 12.

### IN THE EVENT OF DEATH

Your survivors may become eligible for benefits under both the GM Insurance Program and the GM Retirement Program. In addition, coverage is available for your spouse and dependents under the Insurance Program.

#### GM INSURANCE PROGRAM BENEFITS

You are eligible for basic life, extra accident, and survivor income benefit insurance on the first day of the month following the month in which you commence working with General Motors. In addition, these coverages will be provided for an employee who dies, prior to becoming insured, as a result of accidental bodily injuries caused solely by employment with General Motors.

If you are not at work on the date your insurance coverages would otherwise start, such coverages start the day you return to work.

General Motors pays the full cost of this insurance while you are at work.

You may increase the amount of your survivor benefits by enrolling for optional group life insurance or personal accident insurance, or both. You pay the cost of these additional coverages.

#### YOUR BASIC LIFE INSURANCE PRIOR TO AGE 65 . . .

is equal to 24 times your monthly base salary. Base salary, for this purpose, includes premium for necessary continuous 7-day operations but does not include overtime, night shift premium or any cost of living allowance.

You have the right to designate your beneficiary or beneficiaries and to change your beneficiary designation at any time.

Basic life insurance benefits are payable to your designated beneficiary if you should die from any cause while covered for life insurance. Your beneficiary may elect to receive benefits in a lump sum or in monthly instalments under one of the optional income plans.

#### YOUR EXTRA ACCIDENT INSURANCE . . .

is provided while you are insured for basic life insurance to age 65 and is equal to one-half of your basic life insurance.

If you should die as the result of an accident while covered for extra accident insurance, your beneficiary will receive this insurance in addition to any other benefits payable in the event of death.

For extra accident insurance to be payable, your death must occur within one year following the accident and must not be due to disease, self-inflicted injury or any act of war.

#### IF DEATH SHOULD OCCUR AS THE RESULT OF AN ACCIDENT WHILE ON COMPANY BUSINESS . . .

an additional benefit will be paid equal to the amount of your extra accident insurance that is payable.

#### To Apply for Life and Extra Accident Insurance Benefits . . .

a beneficiary must make a claim on a form provided by General Motors for that purpose and return it to the GM unit where you last worked.

#### YOUR SURVIVOR INCOME BENEFIT INSURANCE . . .

is in force while you are insured for extra accident insurance and provides monthly payments in addition to your basic life and extra accident insurance. Two kinds

of survivor income benefits are provided to eligible survivors of employees: a transition benefit and a bridge benefit.

#### • A Transition Benefit . . .

of \$300 per month may be payable to your eligible survivors for up to 24 months.

However, the transition benefit will be \$175 if the survivors are or become eligible for certain Social Security benefits.

#### • A Bridge Benefit . . .

of \$300 per month may be payable to your surviving spouse. To be eligible she or he must be at least age 45, or your surviving spouse's age, when combined with your years of participation, must total 55 or more, on the date of your death. In either case, your surviving spouse must have been married to you for at least one year.

The bridge benefit will begin after payment of the 24th transition benefit. Bridge benefits cease if the surviving spouse remarries or attains age 62 or the age at which full widow's or widower's insurance benefits or old age benefits become payable under Social Security, or dies.

Bridge benefits are not payable for any month for which a surviving spouse could qualify for a mother's or father's insurance benefit under Social Security, whether or not she or he actually receives the mother's or father's benefit.

#### To Apply for Survivor Income Benefits . . .

an eligible survivor must make a claim on a form provided by General Motors for that purpose and return it to the GM unit where you last worked.

• An Elible Widow or  
Widower . . .

may waive survivor income benefits in order to receive a higher monthly benefit under the GM Retirement Program.

The waiver can become effective as early as the first day retirement benefits are payable if the waiver is received by General Motors on or before the date the survivor applies for survivor income benefits. The waiver may be terminated at any time. The termination will become effective the first day of the second month following receipt by General Motors of appropriate notice from the survivor.

CONTINUING INSURANCE  
AFTER AGE 65

If you have 10 or more years of participation (see page 46) when you reach age 65, your basic life insurance will be continued without cost to you for your lifetime. However, the amount of your basic life insurance will be reduced each month by 2% of the amount you had in force at age 65 until the amount equals 1½% for each year of participation times the amount in force at age 65.

For example, an employee with 30 years of participation who has \$50,000 of basic life insurance at age 65 would have \$22,500 of continuing life insurance after all reductions, as follows:

$$1\frac{1}{2}\% \times 30 = 45\% \times \$50,000 = \$22,500.$$

While you are at work for General Motors after age 65, your basic life insurance is continued for you subject to the age 65 reduction provisions. However, effective January 1, 1979, years of participation which you accrue after age 65 and any changes in your monthly base salary after age 65 will be used in determining the amount of continuing life insurance. Extra accident, survivor in-

come benefit, sickness and accident and extended disability benefit insurance continue while you are in active service so long as basic life insurance remains in force.

If you terminate employment with General Motors for any reason after age 65, your extra accident, survivor income benefit, sickness and accident and extended disability benefit insurance coverages are canceled at the time you terminate employment. Your basic life insurance also is canceled if you do not have 10 years of participation at the time you terminate employment.

IN ADDITION TO THE COVERAGES PROVIDED AT  
NO COST TO YOU, THE FOLLOWING PROTECTION  
IS AVAILABLE UNDER THE INSURANCE  
PROGRAM:

Optional Group Life Insurance

You May Enroll for Optional  
Group Life Insurance . . .

in amounts of \$5,000, \$10,000 or \$15,000 or 1, 2, 3, 4 or 5 times your annual base salary. Annual base salary, for this purpose, equals 12 times your monthly base salary. Base salary includes premium for necessary continuous 7-day operations but does not include overtime, night shift premium or any cost of living allowance.

This insurance is in addition to your basic life insurance and is available to regular employees with 6 or more months of service while basic life insurance is in force.

You have the right to designate your beneficiary or beneficiaries. The beneficiary need not be the same as you designated for your basic life insurance.

You Contribute . . .

the full cost of optional group life insurance. Your local insurance office can advise you of the current monthly

contribution rate for your age group. Rates are subject to change by the insurance company.

#### When You Attain Age 66 . . .

the amount of optional group life insurance in force on your 65th birthday will be reduced by 20% and by a like amount each year to age 70. You will be required to contribute for the coverage remaining in force. No optional group life insurance will be provided after the end of the month in which you attain age 70.

#### Additional Information . . .

concerning optional group life insurance is available in the enrollment folder which describes this coverage.

#### Dependent Group Life Insurance

Effective January 1, 1980, Increased  
Dependent Group Life Insurance  
Became Available . . .

which will provide up to \$50,000 on your spouse and up to \$10,000 on each eligible child in increments of \$10,000 and \$2,000, respectively, if you elect to enroll.

You are eligible for this coverage if you are insured for at least \$5,000 of optional group life insurance and have an eligible dependent.

You are the beneficiary for dependent group life insurance. Benefits are payable to you in a lump sum if an eligible dependent should die from any cause while you are insured for dependent group life insurance.

An eligible dependent includes your spouse, and dependent children over 14 days of age who are eligible to be covered for basic Health Care coverages (excluding sponsored dependents).

#### You Contribute . . .

the full cost of dependent group life insurance. Your insurance office can advise you of the current monthly contribution rate for your age group. Rates are subject to change by the insurance company.

#### You May Continue . . .

dependent group life insurance to age 70 if you are insured for optional group life insurance. You must pay the required monthly contribution.

#### Additional Information . . .

concerning dependent group life insurance is available in the enrollment folder which describes this coverage.

#### Personal Accident Insurance

You May Enroll For Personal  
Accident Insurance . . .

in amounts from \$10,000 to \$250,000. You also may enroll your spouse and any eligible dependent children for this insurance. The maximum dependent coverage available is \$100,000 for your spouse and \$30,000 for each child. However, after you are age 70, insurance in force on any person insured may not exceed \$50,000.

You contribute the full cost of personal accident insurance. Your insurance office can advise you of the premium rates.

Benefits are payable to the designated beneficiary if you, your spouse or dependent child die by accidental means provided death was not the result of self-inflicted injury, experimental or test flight in an aircraft, or any act of war.

Detailed information concerning personal accident insurance and enrollment cards are contained in the booklet, "Personal Accident Insurance".

## GM RETIREMENT PROGRAM SURVIVOR BENEFITS

In addition to benefits under the GM Insurance Program, your survivors may receive GM Retirement Program benefits under Part A and/or Part B.

### If You Die Before Retirement

#### Part A Automatic Benefit For Your Surviving Spouse

If you die after attaining eligibility to retire voluntarily and have been married at least one year, a lifetime monthly Part A basic benefit may be payable automatically to your surviving spouse.

Your spouse's monthly benefit would be 60% of the monthly Part A basic benefit you would have received had you retired voluntarily and elected the survivor option.

#### Part B Optional Benefit For Your Surviving Spouse

You may elect this option on a form provided by the personnel department when you first become eligible to participate in Part B of the Program, provided you are then married. If you marry thereafter, you may elect this option on a form provided by the personnel department to become effective after one year of marriage.

If you die while this option is in effect, your surviving spouse will receive a monthly benefit equal to 60% of your unreduced accrued Part B primary and supplementary benefits.

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### FOR EXAMPLE . . .

suppose you have this Part B survivor option in effect and you die in October, 1981 at age 50 before you are eligible to retire voluntarily. You and your spouse are the same age, your average monthly base salary is \$2,000, you have contributed \$7,000 to Part B of the Program, and have 25 years of credited service. Your spouse would receive monthly benefits equal to 60% of your accrued Part B benefits, or, in this case, an estimated \$250 a month for life.

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If you are eligible to retire voluntarily on the date of your death and have this option in effect, your surviving spouse would receive 60% of the accrued Part B primary and supplementary benefit *plus* the Part A survivor benefit (or survivor income benefits under the GM Insurance Program as discussed on pages 35 and 36).

This option generally remains in effect until you are eligible to elect the survivor option after retirement, your employment terminates, you become divorced, you submit to General Motors your written revocation of the election, you are transferred to the hourly rolls for one year, or you withdraw from Part B of the Program.

### If You Die After Retirement

#### Part A Basic and Part B Surviving Spouse Benefits

When you retire, you have the option to provide lifetime monthly benefits for your eligible surviving spouse after your death. This option will not be effective prior to one full year of marriage. If you elect the surviving spouse option, your benefits will be reduced by 5% provided the age difference between you and your spouse is not more than 5 years. If the age difference exceeds 5 years, your

benefits will be further adjusted. Your surviving spouse's monthly benefit would be 60% of the monthly Part A basic and/or Part B benefits payable to you.

Generally, this survivor option becomes effective on the date you retire. However, if you retire due to disability before age 55 with less than 30 years of credited service, this option becomes effective at age 55. Prior to age 55, the following would apply:

- Under Part A, you may provide your spouse an actuarially determined 50% joint and survivor option (described below), and
- Any Part B optional benefit for your surviving spouse (described on page 38) would continue in effect until you attain age 55.

If you outlive your spouse or are divorced, you may cancel the Part A survivor option.

After retirement you may revoke both Part A and Part B survivor options. Consent of General Motors and/or the Metropolitan Life Insurance Company is necessary for any revocation while your spouse is alive.

If you cancel or revoke the option, your future benefits will be restored, upon application on a form available in the personnel department, to the amount payable without the option. Your previously designated survivor no longer would be eligible for a benefit.

If you marry or re-marry after you retire, you may elect the surviving spouse option under Part A of the program for your new spouse. This option is available only if you had not rejected the surviving spouse option for a previous spouse when it first was made available to you. The marriage or re-marriage provision is not applicable to Part B benefits.

### If Your Spouse Is Receiving A Survivor Income Benefit . . .

under the GM Insurance Program, the Retirement Program Part A surviving spouse benefit will not be payable while monthly survivor income benefits are payable under the GM Insurance Program.

### Special Benefit

When your surviving spouse is receiving a monthly Part A retirement benefit, the special benefit described on pages 17 and 18 also becomes payable upon attainment of age 65. This benefit can become payable prior to age 65, upon application, if your surviving spouse is receiving a monthly Part A retirement benefit and is enrolled for Part B of Medicare under Social Security.

### Part A Basic and Part B Joint and Survivor Benefits—All Retirements

As an alternative to the surviving spouse option, you may elect a joint and survivor option. Under this option all or any part of your reduced monthly Part A basic and Part B benefits may be continued to any beneficiary you designate. For further information on this option, contact your personnel department.

### Part A Joint and Survivor Option—Disability Retirement

If you retire due to total and permanent disability before age 55 with less than 30 years of credited service, you may provide a 50% joint and survivor (J&S) option for your spouse. The J&S option would pay your spouse 50% of your actuarially reduced monthly Part A basic benefit in the event you die before your spouse.

This option is applicable only if you are married on the date of the option election and throughout the one year period ending on the date of your death. Moreover, ex-

cept for accidental death, J&S benefits are not payable if you die within two years of the date of the option election. Benefit payments to the survivor commence on the first of the month following the month you would have attained age 55. J&S benefits are not payable while monthly survivor income benefit insurance is payable under the GM Insurance Program.

Once the J&S option becomes effective, it cannot be canceled until age 55. If your spouse should die or you are divorced before age 55, your benefits would continue to be reduced for your lifetime.

The regular survivor option (described on page 39) becomes available on the first of the month following your attainment of age 55, whether or not you reject the J&S option. This means that you may reject the J&S option prior to age 55 and elect the regular survivor option at age 55.

## HEALTH CARE BENEFITS FOR SURVIVORS

### If You Die Before You Are Eligible To Retire Voluntarily . . .

your surviving spouse and dependent children are eligible while receiving survivor income benefits to be covered for the same Health Care coverages (except vision and dental) as were available to you. The full cost of this protection must be paid for by the surviving spouse. However, if he or she is eligible for a bridge benefit (as described on page 36), General Motors will pay the full cost for the first six months of basic Health Care protection.

If you were not eligible to retire voluntarily at the time of your death but you had elected the Part B optional survivor benefit and had at least 10 years of credited service under the Retirement Program, your spouse and eligible dependent children will be eligible for continued Health Care coverages (except vision prior to October 1,

1980). General Motors will continue to pay for basic coverages and for most of the cost of comprehensive medical expense insurance coverage. General Motors also will continue these coverages if you die as a result of accidental bodily injury caused solely by employment with General Motors. Health Care coverages will cease if your surviving spouse remarries or dies.

A surviving spouse age 65 or older who is eligible but not enrolled for Medicare Part B coverage is not eligible for GM payment for any Health Care coverages.

### If You Die After Retirement Or After You Are Eligible To Retire Voluntarily . . .

all Health Care coverages (except vision prior to October 1, 1980) that were available to you will be provided to your surviving spouse and eligible dependent children.

General Motors will continue to pay for basic coverages and for most of the cost of comprehensive medical expense insurance coverage except when you retired voluntarily as early as age 55 and prior to age 60 and your combined years of age and credited service totaled less than 85. In this case your surviving spouse would be required to pay the full monthly cost of these coverages.

A surviving spouse age 65 or older who is eligible but not enrolled for Medicare Part B coverage is not eligible for GM payment for any Health Care coverages.

## SAVINGS-STOCK PURCHASE PROGRAM BENEFITS FOR SURVIVING SPOUSE

If you die while employed, and your surviving spouse is your beneficiary under this Program, he or she will receive your entire account balance, including all GM contributions.

In lieu of a lump sum settlement, your surviving spouse may convert all or part of the eligible assets to a lifetime annuity, provided your surviving spouse was the beneficiary of at least \$5,000 of assets eligible for such conversion.

#### EMPLOYEE STOCK OWNERSHIP PLAN

In the event of your death, your designated beneficiary or estate will receive all assets to which you would have been entitled following termination of employment (see page 48).

#### IF YOU ARE LAID OFF

If you are a regular classified salaried employee with length of service of one or more years and are placed on layoff-inactive status, as described in the booklet "Working With General Motors," you may be eligible for semi-monthly payments under the Layoff Benefit Plan. For purposes of this Plan, length of service will include all unbroken salaried and hourly service with General Motors.

Unclassified employees are covered by the Separation Allowance Plan described on the next page.

#### LAYOFF BENEFITS

The Amount of Layoff Benefits . . .

is based on your base salary at time of layoff plus the cost of living allowance (COLA) applicable to the semi-monthly period for which the layoff benefit is being paid. The monthly total of semi-monthly payments will be based on:

- 75% of your monthly pay (including COLA) for the first 6 months of layoff for which benefits are payable, and
- 60% of your monthly pay (including COLA) for up to the next 6 months of the continuing layoff for which benefits are payable.

The following amounts, if any, will be *deducted* from the amount of your layoff benefits:

- any unemployment compensation (UC) received or to which you are entitled, and any state disability benefits received; plus
- any GM pay received or made available; plus
- 75% of any earnings received from another employer or from self employment; plus
- any unemployment payments to which you are entitled under any GM plan or program to which General Motors has contributed.

Layoff benefits will be payable automatically. You do not have to file an application to receive layoff benefits.

#### FOR EXAMPLE . . .

assume you have 2 or more years of length of service, are married and have 2 dependent children, you live and work in Detroit, Michigan, and you are laid off January 1, 1980 with a monthly base salary of \$2,160 (including the monthly equivalent of cost of living allowance):

Month of January 1980

Base Salary (including COLA)	\$2,160.00
75% of base salary (including COLA)*	1,620.00
1st Semi-Monthly Period (1st-15th):	
Benefit level ( $\frac{1}{2}$ of \$1,620)	810.00
Less: State UC for period **	228.57
Less: Earnings and other benefits	—0—
GM layoff benefit payable	581.43
2nd Semi-Monthly Period (16th-31st):	
Benefit level ( $\frac{1}{2}$ of \$1,620)	810.00
Less: State UC for period	292.57
Less: Earnings and other benefits	—0—
GM layoff benefit payable	517.43
Total GM Layoff Benefits payable for month	1,098.86
Total UC payable for month	521.14
Total layoff income for January	1,620.00

\* Layoff Benefit calculation would be based on 60% of monthly base salary (including the then applicable cost of living allowance) starting with the 7th month of continuing layoff for which benefits are payable.

\*\* Michigan unemployment compensation (UC) amount based upon weekly benefit rate of \$128.00.

#### Duration of Layoff Benefits . . .

is based on your length of service when initially placed on layoff-inactive status.

If your length of service is 1 year or more, you may receive layoff benefits for 6 months, plus 1 additional month of benefits for each additional 2 full months of service beyond 1 year—up to a maximum entitlement of 12 months of layoff benefits. Thus, if you have 2 or more years of service at the time you are initially placed on layoff-inactive status, you may be entitled to the maximum of 12 continuous months of layoff benefits.

#### Initial Benefit Entitlement and Regeneration of Entitlement . . .

will be based on 1 month of entitlement for each 2 full months of service comprised of one or more of the following:

- periods of active service (any month for which pay is received from General Motors);
- any period of GM approved military leave of absence; and
- any period of absence from work because of occupational injury or disease incurred in the course of GM employment and for which you received workers compensation while on GM approved leave of absence;

up to a maximum entitlement of 12 months of layoff benefits for 24 months' service.

For example:

An employee with 16 months length of service was initially laid off for 6 months starting January 1, 1980. The 16 months of active service provided 8 months of layoff benefit entitlement at time of layoff. The em-

ployee returned to work on July 1, 1980 with 2 months of unused benefit entitlement remaining to his credit.

After working 14 months, the employee is again laid off on September 1, 1981. During the 14 months of active service, the employee regenerated 7 months of layoff benefit entitlement which, when added to the 2 months of entitlement remaining after the first layoff period, provides 9 months of layoff benefit entitlement for the layoff period starting September 1, 1981.

#### Information Required

At time of layoff, you will be requested to complete a data statement indicating the address where you want your layoff benefit checks to be mailed and certain information with respect to your unemployment compensation benefit status and estimated outside earnings.

At the end of each month of layoff-inactive status (or at other times as deemed necessary) you will be required to complete a certification statement with respect to the past month, giving information concerning the amounts of unemployment compensation received or, if denied, for what reason; the amount of any earnings received or receivable; the amount of any other benefits or payments for unemployment received or receivable; an estimate of any earnings to be received for the following month; and any other information relative to your entitlement or benefit amount. This certification statement must be returned promptly so that any necessary adjustments can be made and not delay the layoff benefit payable for the next month.

#### SEPARATION ALLOWANCE PLAN

##### Unclassified Employees . . .

who have at least 12 months length of service, and are placed on layoff-inactive status, will be eligible for layoff allowance payments under the Separation Allowance Plan.

Such payments are based on your "average monthly salary" as defined in the Plan. The maximum amount of separation allowance ranges from one-half of average monthly salary for employees with 1 to 3 years of service to 12 times average monthly salary for employees with 29 or more years of service.

The Separation Allowance Plan is discussed in the booklet "Working With General Motors".

#### OTHER BENEFIT PROGRAM COVERAGES WHILE ON LAYOFF

##### Health Care Coverages

If you have length of service of at least one year, your basic Health Care coverages (excluding dental) will continue to be provided at GM's expense for up to 13 months. These coverages are available for up to 12 additional months, based on your length of service, if you pay the full monthly contribution.

If you have been employed by General Motors for less than 1 year, your basic Health Care coverages may be continued for a number of months equal to the period of your employment. You must pay one-half the monthly contribution.

You may continue your comprehensive medical expense insurance coverage by paying the required monthly employee contribution while your basic coverages remain in effect. Your dental coverage will be continued only to the end of the month following the month in which you last worked.

##### Retirement Program

You may continue to accrue credited service for up to 11 months while on layoff. However, you cannot make contributions while on layoff.

If layoff occurs after you have attained age 40 and you reach age 55 with 10 or more years of unbroken credited service, you may qualify for special early retirement with unreduced benefits.

If your layoff continues for longer than 12 months, you may have your Part B contributions returned to you with interest. In lieu of a return of contributions, you may elect to receive a paid-up annuity certificate. If you are later rehired in a GM salaried position before your continuous service is broken, and you immediately resume contributing under Part B, you may return your annuity certificate and have your Part B benefits reinstated.

If, after 12 months of layoff you have 10 or more years of credited service which would remain unbroken upon your attaining age 55, you may leave your contributions in the Program until you retire.

#### Savings-Stock Purchase Program

No savings are permitted, although you have the following rights in your various classes:

#### For Classes Which Have Not Matured

- During the period you remain on layoff-inactive status, you may leave your assets in this Program and continue to earn out GM contributions. You retain the usual withdrawal privileges.
- Upon separation from layoff-inactive status:

If your continuous employment at date of layoff was 5 or more years, you will receive a full distribution of all assets in your account, including all GM contributions.

If continuous employment was less than 5 years, you will receive assets attributable to your savings and related earnings plus those assets, including earnings,

attributable to GM contributions which have been earned out.

#### For Classes Which Have Matured

- During the period you remain on layoff-inactive status, you may leave all assets in the Program until your separation from inactive status. You retain the usual withdrawal privileges.
- Upon separation from inactive status, you will receive all your assets in the Program including GM contributions previously earned out in full.

#### Employee Stock Ownership Plan

You will receive a full distribution of your entire account balance, in the year following the year you complete 12 months of layoff.

#### Life and Disability Insurance

For the first month following the month in which you last worked prior to layoff, basic life, extra accident, survivor income benefit, sickness and accident, if any, and extended disability benefit insurance will be continued at GM expense.

Thereafter, you may continue basic life, extra accident, and survivor income benefit insurance for the next 12 months. If you had one or more years of recognized length of service when your layoff commenced, General Motors will pay for your insurance for this 12-month period.

Following this period, while your GM length of service remains unbroken, you may continue basic life, extra accident, and survivor income benefit insurance for up to an additional 12 months of layoff.

You must contribute 50 cents for each \$1,000 of basic life insurance for any month in which General Motors

does not contribute. You must pay the required monthly contributions to continue optional and dependent group life insurance while basic life insurance remains in force.

If you become disabled while on layoff-inactive status, and sickness and accident insurance is not in force, benefits may be continued up to your maximum entitlement under the Layoff Benefit Plan. If you continue to be disabled after you have received layoff benefits or separation allowance for your maximum entitlement, you may be eligible for monthly extended disability benefits (see pages 29 and 30).

At the time of layoff, you will be given a notice explaining your insurance continuance privileges and any monthly contributions you may have to make.

#### Personal Accident Insurance

You may continue this coverage on yourself and any eligible dependents for 12 to 24 months, depending on the method you use to pay premiums and the premium due date.

## GENERAL INFORMATION ABOUT YOUR BENEFITS

### GENERAL MOTORS PAYS THE FULL COST OF . . .

Part A of the Retirement Program, basic Health Care coverages, basic life and disability insurance, and the Layoff Benefit Plan. In addition, General Motors contributes most of the cost of Part B of the Retirement Program and the Comprehensive Medical Expense Insurance Program. Under the Savings-Stock Purchase Program, General Motors contributes \$1.00 for each \$1.00 an employee saves up to 5% of eligible salary and \$.60 for each \$1.00 an employee saves from 5% to 10% of eligible salary.

The amounts of Retirement Program contributions are actuarially determined. General Motors makes periodic contributions to the Layoff Benefit Plan to maintain the level of the fund at two times the average monthly gross payments paid to employees during the last 12 months.

All basic coverages under the Insurance Program are paid for by General Motors while you are in active service. The amounts of Insurance Program contributions are determined by the carriers.

The Employee Stock Ownership Plan is provided to classified employees at no cost to them. Employees may contribute to the Plan to receive additional matching GM contributions to their account. Other benefits made available by General Motors, the full costs of which are borne by employees, are optional group life insurance, dependent group life insurance, and personal accident insurance.

### WHEN INSURANCE COVERAGES START

Basic life, extra accident and survivor income benefit insurance coverages start on the first day of the month

following the month in which your employment commenced.

Sickness and accident and extended disability benefit insurance coverages start on the first day of the fourth month following the month in which your employment commenced.

Health Care coverages, except for dental, hearing aid and vision coverages, start on the first day of the fourth month following the month in which your employment commenced (third month prior to October 1, 1980).

Dental, hearing aid and vision coverages start on the first day of the month which follows the month in which you were actively at work after acquiring one year of service.

If you are not at work on the day of your basic life, extra accident, survivor income benefit, sickness and accident, and extended disability benefit insurance coverages would otherwise start, coverages start the day you return to work.

#### CESSATION OF INSURANCE COVERAGE

Basic life, extra accident, survivor income benefit, sickness and accident, and extended disability benefit insurance coverages cease on the day you quit voluntarily or are discharged. Health Care coverages cease at the end of the month in which you quit voluntarily or are discharged. If your employment is terminated for any other reason, except retirement, all coverages continue until the end of the month in which length of service is broken.

Optional and dependent group life insurance cease immediately if you quit voluntarily or are discharged. If you leave General Motors for any other reason except retirement, insurance continues until the end of the month in which your length of service is broken. If you fail to make a required monthly contribution, insurance

will cease at the end of the month preceding the month for which the contribution was due. Dependent group life insurance coverage also ceases for any person when that person no longer is an eligible dependent.

#### YEARS OF PARTICIPATION UNDER THE INSURANCE PROGRAM

Prior to September 1, 1950 . . .

years of participation, in general, equal your recognized length of service at September 1, 1950.

From September 1, 1950 through  
December 31, 1973 . . .

you receive credit prior to age 65 while insured for life insurance, plus any period while on military leave or while receiving your life insurance in instalments because of total and permanent disability. If you are not insured for a period in excess of 24 consecutive months and your recognized length of service is broken, you lose credit for prior years of participation.

If your credited service under the GM Retirement Program is greater than your years of participation, credited service may be used instead of years of participation.

On and After January 1, 1974

For insurance purposes, your credited service accrued on and after January 1, 1974 under the Retirement Program will be added to your years of participation under the Insurance Program (or credited service, if greater) as of December 31, 1973. In addition, if you work beyond age 65, your years of participation will include the greater of all periods during which you are insured for basic life insurance after the month you attain age 65 and prior to the date your length of service

is broken, or any credited service accrued under the Retirement Program after you attain age 65.

#### INSURANCE CERTIFICATES...

containing all the detailed provisions of the group insurance benefit coverages you have under the policies issued to General Motors Corporation by its insurance carriers will be made available to you.

#### YOUR GM LENGTH OF SERVICE...

is your period of employment with an employing unit of General Motors which is considered unbroken. Your length of service is important to you because it determines the extent of your participation in various employee benefit programs.

Length of service is not recognized until you attain the status of a regular employee.

You become a regular employee upon completion of your probationary period of employment, generally after 6 continuous months of salaried employment. This 6 months is then included in your length of service.

For more information about length of service, contact your supervisor or salaried personnel representative or refer to the salaried employee handbook "Working With General Motors".

#### BENEFITS FOR PART-TIME EMPLOYEES

Only those part-time salaried employees who are regularly scheduled to work at least half their employing unit's base work week may participate in the GM benefit programs for salaried employees. Generally, the level of coverage is proportional to time worked.

#### TEMPORARY EMPLOYEES

Employees who are employed on a day-to-day basis (for example, to perform short-term emergency work) may not participate in any of the GM benefit programs.

#### BENEFITS FOR COMMISSION SALES EMPLOYEES

Employees who are compensated in whole or in part on a sales commission basis may participate in the GM Savings-Stock Purchase Program, Retirement Program, Employee Stock Ownership Plan (ESOP), Insurance Program and the Layoff Benefit Plan. The extent of their participation, with the exception of ESOP, is determined by an "annual earnings base" schedule established by General Motors.

#### BENEFIT PROGRAM COVERAGES WHILE ON NON-DISABILITY LEAVE

If you are granted a leave of absence for a reason other than disability, you can continue your benefit coverages as described below:

##### Health Care Coverages

Your basic Health Care coverages may be continued for up to 12 months (or for the duration if on educational leave) provided you pay one-half the monthly subscription or contribution charge. Dental coverages may not be continued.

If you are granted a non-disability leave of absence in anticipation of disability, your Health Care coverages may be continued at GM expense starting the first of the month following certification of disability provided you continue your basic Health Care coverages in force by making the required monthly contribution during your non-disability leave.

You may continue your comprehensive medical expense insurance coverage by paying the usual monthly employee contribution while your basic coverages remain in effect.

### Retirement Program

Generally, you continue to be covered by the provisions of the Program while on leave. However, you cannot make contributions, and no credit service can accrue except in the case of an approved military leave of absence.

### Savings-Stock Purchase Program

Although no additional savings are permitted, you may leave your assets in the Program and continue to earn out GM's contributions.

### Life and Disability Insurance

For the first month following the month you last work prior to an approved leave of absence other than for disability, basic life, extra accident, survivor income benefit, sickness and accident, and extended disability benefit insurance will be continued with General Motors paying the cost.

Thereafter, you may continue basic life, extra accident, and survivor income benefit insurance for the next 11 months (or for the duration of an educational leave) provided you contribute 50 cents for each \$1,000 of basic life insurance.

Sickness and accident and extended disability benefit insurance may be reinstated if you were granted a non-disability leave of absence because of a medical condition that may be expected to result in total disability in the future, (e.g., anticipated surgery or termination of pregnancy). For insurance to be reinstated you must have been making contributions to continue your basic

life insurance and present medical evidence satisfactory to the insurance company that you are totally disabled.

General Motors will pay the full cost of your life and disability insurance starting the first of the month in which you present evidence of total disability satisfactory to General Motors. General Motors will continue to pay the full cost of your insurance coverages on the same basis as provided for an employee on a disability leave as described on page 34.

You must pay the required monthly contributions to continue optional and dependent group life insurance while basic life insurance remains in force.

### Personal Accident Insurance

You may continue this coverage on yourself and any eligible dependents for 12 to 24 months, depending on the method you use to pay premiums and the premium due date.

### IF YOU LEAVE GENERAL MOTORS . . .

prior to retirement, you will have certain rights and be required to make certain decisions relative to your benefit program coverages, as described below:

### Insurance Program Conversion Privileges

During the 31 days following cancellation of your insurance coverages . . .

- You may convert at your expense to whatever "direct pay" individual contract for basic Health Care (but not dental or vision) coverage is then available from the local plan in which you have been enrolled. Application may be made in accordance with a notice which you will receive from the local plan or from your GM employing unit. Comprehensive medical expense insurance coverage may not be converted.

- You may convert at your expense all or part of your basic life, survivor income benefit, and/or optional group life insurance to an individual policy without medical examination. Dependent group life insurance may be converted only by your dependents. Any type of life insurance policy, except term insurance, then being issued by Metropolitan Life may be selected. Application may be made at any local office of Metropolitan Life or at its home office, One Madison Avenue, New York, New York 10010.
- Your personal accident insurance may be converted at your expense to an individual policy of personal accident insurance customarily issued by the Continental Casualty Company. Application may be made directly to the Detroit Insurance Agency, 7650 Second Avenue, Detroit, Michigan 48202.

#### Retirement Program

Part A basic and Part B supplementary benefits—If you leave General Motors before retirement and have 10 or more years of credited service, you will be eligible at age 65 for deferred Part A basic and Part B supplementary benefits, if any. You may elect to have these benefits start as early as age 55 and prior to age 65 on a reduced basis. Benefits would commence only after you have submitted an application which would be given to you following your break in credited service.

Part B primary benefits—If you leave General Motors before retirement, you may:

leave your Part B contributions in the Program,

— or —

withdraw your contributions plus interest.

If you leave your Part B contributions in the Program and have contributed for 5 or more years, you may be entitled to unreduced monthly Part B primary benefits

at age 65, or as early as age 55 on a reduced basis. If you have contributed for less than 5 years, you will receive benefits based only on your contributions.

#### Savings-Stock Purchase Program

If employment ends before class maturity and you have savings in one or more classes which have not matured at the time you leave General Motors, you will receive at least the assets representing your savings plus interest.

Full earn-out of GM contributions will occur prior to maturity of the class if you are terminated as a layoff-separated employee, or special separation, in connection with the sale of a General Motors-owned activity, provided you have 5 or more years of continuous service at the time of your layoff or special separation.

For all other terminations (except discharge), you will receive the earned-out GM contributions.

Regardless of the reason for your termination, you will receive all your Program assets held in trust for matured classes, including fully earned-out GM contributions.

#### Employee Stock Ownership Plan

You will receive two distributions of your account following your termination of employment. The first distribution will be in February following the year of termination. It will consist of your entire balance at that time. In February of the second year following the year of termination, any amount allocated to your account for the year in which you left General Motors will be distributed. You will not receive a plan allocation or have the opportunity to contribute to the Plan for a plan year during which you quit or were discharged.

INFORMATION RELATED TO  
THE EMPLOYEE RETIREMENT  
INCOME SECURITY ACT OF  
1974 (ERISA)

### TYPES OF PLANS

The GM Retirement Program is a defined benefit plan providing trustee and insured retirement benefits to employees who retire, and to their eligible survivors. The GM Insurance Program is an insured welfare benefit plan providing life and disability insurance to employees, as well as Health Care coverages to employees and their eligible dependents. The GM Layoff Benefit Plan is a welfare benefit plan. The GM Layoff Benefit Plan provides trustee benefits while employees are absent from work due to layoff. The GM Savings-Stock Purchase Program is a defined contribution plan providing trustee benefits on a class year basis to employees who elect to participate in this program. The GM Employee Stock Ownership Plan for Salaried Employees is a defined contribution plan providing benefits to classified salaried employees in the form of common stock ownership in General Motors.

Retirement Program trustee benefits, Savings-Stock Purchase Program and Employee Stock Ownership Plan benefits are provided through the National Bank of Detroit. All life and disability benefits and Retirement Program insured benefits, as well as Health Care benefits for certain employees, are provided through the Metropolitan Life Insurance Company. Health Care benefits for other employees are provided through additional insurance companies, a number of local plans providing these coverages, and health maintenance organizations. Layoff Benefit Plan trustee benefits are provided through the Detroit Bank and Trust Company. General Motors is responsible for administration of the plans described in this booklet.

### PLAN YEAR

December 31 is the end of the plan year for the Insurance Program, Savings-Stock Purchase Program, Em-

ployee Stock Ownership Plan and Layoff Benefit Plan. Records of these plans are kept on a calendar year basis. The Retirement Program plan year ends on September 30. Retirement Program records are kept on a fiscal year basis ending September 30.

### NAMED FIDUCIARY

The Finance Committee of General Motors Corporation is the named fiduciary of the plans described in this booklet.

### ADMINISTRATOR

General Motors Corporation is the sponsoring employer and administrator of the benefit plans described in this booklet. The administrator's address is Room 13-266, General Motors Building, Detroit, Michigan 48202.

### IDENTIFICATION NUMBER

General Motors' employer identification number is 38-0572515. Plan numbers are as follows:

PLAN	
Name	Number
Retirement	001
Savings-Stock Purchase	002
Employee Stock Ownership	008
Insurance	501
Layoff Benefit	502
Comprehensive Medical	
Expense Insurance	504

### LEGAL PROCESS

Service of legal process on General Motors Corporation may be made at any office of the CT Corporation. The CT Corporation, which maintains offices in all 50 States, is the statutory agent for service of legal process on Gen-

eral Motors. The procedure for making such service generally is known to practicing attorneys. Service of legal process also may be made upon the administrator at Room 15-253. General Motors Building, Detroit, Michigan 48202.

### PARTICIPANT RIGHTS

As a participant in GM benefit plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled by law to:

Examine, without charge, at the plan administrator's office and at other locations, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report.

Obtain once a year, free of charge, upon written request, a statement telling you whether you have a right to receive a retirement benefit at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get such right.

### FIDUCIARY RESPONSIBILITIES

In addition to creating rights for plan participants, ERISA imposes duties upon the persons who are responsible for the operation of employee benefit plans.

These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the plan participants and they must exercise prudence in the performance of their plan duties.

If your claim for a benefit is denied, in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to a review and reconsideration of your claim.

If you request materials and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If you should file suit for any reason, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you may wish to contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

### BENEFIT GUARANTEE

Certain benefits under the GM Retirement Program are guaranteed by the Pension Benefit Guaranty Corporation (PBGC) if the plan terminates. However, the PBGC guarantees only normal-age retirement benefits, early retirement benefits (up to the amount accrued for normal

retirement), and certain disability and survivor's pensions.

The PBGC guarantees vested benefits at the level in effect on the date of plan termination.

However, if benefits have been increased within five years before plan termination, the benefit increases may not be guaranteed. No benefit increase that has been in effect for less than 12 full months before the plan terminates is guaranteed. Moreover, there is a statutory ceiling on the amount of an individual's monthly benefit that PBGC guarantees. You may wish to address any inquiries you may have to: Pension Benefit Guaranty Corporation, 2020 K Street, N.W., Washington, D.C. 20006 (phone # (202) 254-4817).

#### TRUSTEES

Trustees of the Retirement Program, who accumulate assets through which trustee retirement benefits (Part A and Part B Supplementary) are provided, are as follows:

American National Bank & Trust  
Company of Chicago  
33 La Salle Street  
Chicago, Illinois 60690

Ameritrust  
900 Euclid Avenue  
Cleveland, Ohio 44101

Bank of America, N.T. & S.A.  
Bank of America Center Box 37000  
San Francisco, California 94137

Bankers Trust Company  
280 Park Avenue  
New York, New York 10017

Chase Manhattan Bank, N.A.  
1211 Avenue of the Americas  
New York, New York 10036

Citibank, N.A.  
153 East 53rd Street  
New York, New York 10022

Harris Trust & Savings Bank  
111 West Monroe Street  
Chicago, Illinois 60690

Mellon Bank, N.A.  
Mellon Square  
Pittsburgh, Pennsylvania 15230

Morgan Guaranty Trust Company of N.Y.  
9 West 57th Street  
New York, New York 10019

National Bank of Detroit  
611 Woodward Avenue  
Detroit, Michigan 48232

The First National Bank of Boston  
P.O. Box 1882  
Boston, Massachusetts 02105

The First National Bank of Chicago  
One First National Plaza  
Chicago, Illinois 60670

Wells Fargo Bank, N.A.  
P.O. Box 44029  
San Francisco, California 94144

Insured retirement benefits (Part B Primary) are provided through the following insurance companies:

Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, Connecticut 06115

Metropolitan Life Insurance Company  
One Madison Avenue  
New York, New York 10010

Prudential Life Insurance Company  
Prudential Plaza  
Newark, New Jersey 07101

The Trustee of the Savings-Stock Purchase Program and Employee Stock Ownership Plan, who accumulates assets through which these benefits are provided, is:

National Bank of Detroit  
611 Woodward Avenue  
Detroit, Michigan 48232

The Trustee of the Layoff Benefit Plan, who accumulates assets through which layoff benefits are provided, is:

The Detroit Bank and Trust Company  
211 Fort Street  
Detroit, Michigan 48231

#### APPLICATION AND CLAIMS REVIEW PROCEDURES

To receive benefits under these employee benefit plans, you will need to file an application. Appropriate forms are available from the personnel department at the location where you are employed. After your application is received, your eligibility for benefits will be determined, and you will be advised accordingly. If you do not receive a response within a reasonable period of time, or you have questions about your benefits, please inquire through your supervisor or personnel department.

If your application for benefits is denied in whole or in part, written notice will be made to you as soon as practicable but no later than 90 days after receipt of your application. This notice will include specific reasons for the denial and will refer to the plan provisions upon which the denial is based. The notice also will include a description of any additional information that may be needed if the claim is to be resubmitted. An explanation of the procedure by which you may have your denied claim reviewed also will be included in the notice. The review procedure is summarized below.

Within 60 days after you receive the notice that your claim is denied in whole or in part, you may make a written request to have your claim reviewed. As part of the review you may submit any written comments that you feel may support your claim. You also may review pertinent documents related to your claim. A written decision on your request for review will be furnished to you within 60 days (120 days if special circumstances require an extension of time) after your written request for review is received. This written decision on the review will include the specific reasons for the decision and will set forth specific reference to plan provisions upon which the decision is based.

GM

## [EMBLEM]

**METROPOLITAN LIFE INSURANCE COMPANY**  
 A Mutual Company Incorporated in New York State  
 (Herein called the Insurance Company)

**Group Insurance Certificate**

The Insurance Company certifies that it has issued Group Policies insuring certain Employees of

**GENERAL MOTORS CORPORATION**  
 Affiliated and Subsidiary Companies  
 (Herein called the Employer)

Each Employee, as defined in Part I hereof, shall become insured on the effective dates determined in accordance with Part III hereof for amounts of Insurance determined by the Schedule of Insurance appearing in Part V hereof.

Further, each Employee who is eligible and enrolls shall become insured on the effective dates determined in accordance with Parts XIII and XIV hereof, respectively, for Optional Group Life Insurance and Dependent Group Life Insurance.

The insurance evidenced by this certificate is subject in every respect to all of the provisions of the Group Policies. Certain provisions of the Group Policies principally affecting the Employee are summarized on the following pages of this certificate. All relevant provisions of the Group Policies, whether mentioned or not, apply to the insurance evidenced by this certificate.

Metropolitan Life Insurance Company,

/s/ Richard R. Shinn  
 RICHARD R. SHINN  
 President and Chief Executive Officer

Basic Group Life Insurance  
 Survivor Income Benefit Insurance  
 Extra Accident Insurance  
 Sickness and Accident Insurance  
 Extended Disability Benefit Insurance  
 Optional Group Life Insurance  
 Dependent Group Life Insurance

Form G.4652E  
 Printed in U.S.A.

(1979 Plan)  
 U.S. Salaried

This Certificate replaces as to the insurance described herein any Certificates or Certificate Supplements previously delivered to the Employee under any Group Policy issued by the Insurance Company insuring certain Employees of General Motors Corporation and such prior Certificates or Certificate Supplements are void.

## NOTICES TO THE EMPLOYEE

Except as set forth in Parts IV and XIII hereof, this certificate is non-assignable and the insurance and benefits are non-assignable prior to a loss.

The insurance does not at any time provide paid-up insurance, or loan or cash values.

No agent has authority to accept or waive the required notice or proof of a claim, or to extend the time within which notice or proof must be given.

Basic Group Life Insurance, Extra Accident Insurance, and Total and Permanent Disability Benefits are provided under Group Policy No. 14000-G. Survivor Income Benefit Insurance is provided under Group Policy No. 22500-G. Sickness and Accident Insurance and Extended Disability Benefit Insurance are provided under Group Policy No. 18501-G. Optional Group Life Insurance is provided under Group Policy No. 23600-G, and Dependent Group Life Insurance is provided under Group Policy No. 23950-G. Effective January 1, 1981, any monthly instalments payable under the Total and Permanent Disability Benefits provision for disability commencing on or after that date are provided under Group Policy No. 14000-G(T), and any benefits payable under the Sickness and Accident Insurance for disability occurring on or after that date, and any benefits payable under the Extended Disability Benefit Insurance for disability commencing on or after that date are provided under Group Policy No. 18501-G(T), and such benefits are primarily the liability of the Policyholder under said Group Policies. The Insurance Company is liable for such benefits to the extent that they are not the liability of the Policyholder, and the Group Policies specify the time when, and the circumstances under which, the Insurance Company is so liable. The Insurance Company continues to determine all benefit payments in accordance with the terms and conditions of such Group Policies.

If you should cease active work for any reason, you should find out immediately from your Employer what arrangements, if any, can be made to continue your Group Insurance in force and, if it can be continued, what arrangements you should make regarding any required contributions. If such arrangements cannot be made, or if made and you subsequently fail to make any contributions required by your Employer, you should find out from your Employer what further rights, if any, you have under the Group Policies.

If you leave work because of total disability, you should be sure to submit written notice and proof, as required, within the time limits specified in this certificate.

Group Policies No. 14000-G and No. 23600-G provide that arrangements may be made with the Insurance Company whereby the amount of Basic Group Life Insurance, Optional Group Life Insurance, and Extra Accident Insurance, if any, payable at your death, will be left with the Insurance Company to earn interest or to be paid as an instalment income instead of in one sum. Information concerning such arrangements may be obtained from your Employer upon request.

In the event of the misstatement of your age, the amounts of your insurance or the amounts of any required contributions shall be adjusted to the amounts which you would have been entitled to, or required to contribute, under the Group Policies at your correct age.

In the event any designated Beneficiary should die before you, and your Beneficiary designation does not already provide for the disposition of the deceased Beneficiary's share of the amount of Life Insurance payable at your death, you should immediately contact your Employer with respect to designating a new Beneficiary.

The Home Office of the Insurance Company is located at 1 Madison Avenue, New York, New York 10010.

## SUMMARY OF PROVISIONS PRINCIPALLY AFFECTING THE EMPLOYEE

### PART 1. DEFINITION OF EMPLOYEE

"Employee" means a person regularly employed by the Employer in the United States, or a person so employed outside of the United States or Canada whose services, if discontinued, would be discontinued by recall to the United States, (except an employee who is classified by the Employer as a temporary employee or a GM co-operative student, and an employee represented for collective bargaining purposes by a labor organization with which no written agreement has been reached making available the insurance provided under the Group Policies) who is classified by the Employer in one of the following classes:

- (1) Salaried Employees who are scheduled to work the normal base work week.
- (2) Part-time salaried Employees, except part-time physicians, who, on a regular and continuing basis, perform jobs having definitely established working hours, but the complete performance of which requires fewer hours of work than the regular work week, provided the services of such Employees are normally available for at least half of the employing unit's regular work week.
- (3) Part-time physicians who are paid monthly salaries and who, without further considerations such as fees or other forms of remuneration, agree to render on a regular and continuing basis such medical services as may be required.
- (4) Employees compensated wholly or in part on a commission basis.

### PART II. YEARS OF PARTICIPATION

"Years of Participation" is defined as follows:

- (a) For service prior to September 1, 1950, Years of Participation shall equal the Employee's years of

recognized length of service, as defined by the Employer, plus the number of years of service, if any, as an hourly-rate employee, to September 1, 1950.

- (b) For service subsequent to September 1, 1950 and prior to January 1, 1974, Years of Participation shall be the total duration of all periods after September 1, 1950 and prior to the end of the month in which the Employee attains age 65 during which the Employee was insured for Life Insurance under Group Policy No. 14000-G, whether or not the Employee's service was continuous for such periods, plus any time spent by the Employee on military leave of absence during which the Employee was not insured for Life Insurance under Group Policy No. 14000-G, plus any period during which the Employee received Total and Permanent Disability Benefits under Group Policy No. 14000-G.

After September 1, 1950 and prior to January 1, 1974, any Employee who is not insured for Life Insurance under Group Policy No. 14000-G for the whole of a period in excess of 24 consecutive months shall lose credit for Years of Participation for any period prior to a subsequent resumption of coverage, except that there shall be no loss of credit for Years of Participation while the Employee's recognized length of service, as defined by the Employer, remains unbroken.

- (c) Notwithstanding the definition of Years of Participation in paragraphs (a) and (b) above, for an Employee actively at work on or after January 1, 1968 and prior to January 1, 1974, who is under age 65 and whose years of credited service, accrued prior to the end of the month in which the Employee attains age 65, under the General Motors Retirement Program for Salaried Employees exceeds the Employee's Years of Participa-

tion, such credited service shall be used for the purposes of such paragraphs (a) and (b) in lieu of Years of Participation as defined herein.

(d) For an employee actively at work on or after January 1, 1974, "Years of Participation" shall be the sum of:

(1) the Employee's Years of Participation determined in accordance with paragraphs (a) and (b) above as of December 31, 1973 or the Employee's credited service accrued under the General Motors Retirement Program for Salaried Employees as of December 31, 1973, whichever is greater, and

(2) the Employee's credited service accrued after December 31, 1973 and prior to the end of the month in which the Employee attains age 65, under any pension plan or retirement program to which the Employer has contributed,

and, for an Employee with unbroken length of service on or after January 1, 1979 who continues to work on and after attainment of age 65,

(3) the total duration of all periods during which the employee is insured for Life Insurance under Group Policy No. 14000-G subsequent to the month the Employee attains age 65 and prior to the date length of service is broken, or the Employee's credited service accrued after age 64 under any pension plan or retirement program to which the Employer has contributed, whichever is greater.

### PART III. ELIGIBILITY FOR AND EFFECTIVE DATES OF INSURANCE

#### SECTION A. ELIGIBILITY FOR INSURANCE

An Employee hired prior to September 17, 1979 shall be eligible under the Group Policies

(1) for Basic Group Life, Extra Accident, and Survivor Income Benefit Insurance on that date or, if later, on the first day of the calendar month next following the month in which employment with the Employer commences subsequent to the Employee's most recent date of hire, and

(2) for Sickness and Accident and Extended Disability Benefit Insurance on that date or, if later, on the first day of the third calendar month next following the month in which employment with the Employer commences subsequent to the Employee's most recent date of hire.

An Employee hired on or after September 17, 1979 shall be eligible under the Group Policies for Basic Group Life, Extra Accident, and Survivor Income Benefit Insurance on the first day of the calendar month next following the month in which employment with the Employer commences subsequent to the Employee's most recent date of hire, as determined by the Employer, and for Sickness and Accident and Extended Disability Benefit Insurance on the first day of the fourth calendar month next following the month in which employment with the Employer commences subsequent to the Employee's most recent date of hire, as determined by the Employer.

An Employee in an unclassified salaried position as determined by the Employer shall not be eligible for Sickness and Accident Insurance.

#### SECTION B. EFFECTIVE DATES OF INSURANCE

The insurance specified in Section A of this Part III shall become effective on the dates of the Employee's eligibility, provided the Employee is actively at work on each such date of eligibility. If the Employee is not actively at work on the date when such insurance under the Group Policies would otherwise become effective, such

insurance shall become effective on the next following day on which the Employee is actively at work, provided that date is not more than 24 months later or, if such date is more than 24 months later, the Employee has not then broken recognized length of service as defined by the Employer.

The provisions of this Section B to the contrary notwithstanding, Basic Group Life, Extra Accident, and Survivor Income Benefit Insurance for an Employee hired on or after September 17, 1979, shall be provided prior to the date such insurance under the Group Policies would otherwise become effective as specified in the preceding paragraph, for death caused by accidental bodily injury caused solely by the Employee's employment with the Employer for which a benefit would otherwise be payable under Part VIII hereof, but only if the bodily injury results solely from an accident in which both the cause and result are unexpected and definite as to time and place.

#### PART IV. ASSIGNMENT

An Employee who is compensated at a monthly base salary of \$1,000 or more, or who was compensated at a monthly base salary of \$1,000 or more immediately prior to the Employee's 70th birthday or the date of the Employee's retirement, whichever first occurred, may transfer by absolute and irrevocable assignment all the Employee's rights, title, interests and incidents of ownership, both present and future, under Group Policy No. 14000-G. No assignment shall be binding upon the Insurance Company unless it is in a form acceptable to the Insurance Company and until it has been accepted and filed at the Home Office of the Insurance Company. The Insurance Company and the Employer assume no obligation as to the validity or sufficiency of any assignment.

An assignment made pursuant to the above will not destroy the right to the death benefits of a beneficiary

(or beneficiaries) last designated prior to such assignment and will leave unimpaired any Optional Mode of Settlement previously elected pursuant to the Section entitled "Optional Modes of Settlement" of Group Policy No. 14000-G relating to the death benefits payable to such beneficiary (or beneficiaries) in effect at the time of the assignment, if the assignee does not revoke the interest of such beneficiary (or beneficiaries), and if such beneficiary (or beneficiaries) survives the Employee.

As to any other Employee, the Employee's rights, title, interests and incidents of ownership under Group Policy No. 14000-G are non-assignable and the insurance and benefits provided thereunder are non-assignable prior to a loss.

#### PART V. SCHEDULE OF INSURANCE

(A) The following schedule is applicable to an Employee with monthly base salary.

Coverage	Amount of Insurance
Basic Group Life Insurance	24 times monthly base salary, but not less than \$11,700 * for full-time Employee (see Note 1)
Extra Accident Insurance	50% of Basic Group Life Insurance
Survivor Income Benefit Insurance	As specified in Part VII hereof
Sickness and Accident Insurance (Monthly Benefit)	
Employees in classified salaried positions	75% of monthly base salary, but not less than \$370 * per month for full-time Employee (see Notes 2 and 3)
Employees in unclassified salaried positions	None
Extended Disability Benefit Insurance (Monthly Benefit)	60% of monthly base salary, but not less than \$345 * per month for full-time Employee (see Note 2)

Monthly base salary includes any premium for 7-day operations but does not include any overtime, night shift premium, or cost-of-living allowance.

(B) The following schedule is applicable to an Employee compensated wholly or partially on a commission basis.

Basic Group Life Insurance	2 times annual earnings base, but not less than \$11,700 * for full-time Employee, nor more than \$68,000 (see Note 1)
Extra Accident Insurance	50% of Basic Group Life Insurance
Survivor Income Benefit Insurance	As specified in Part VII hereof
Sickness and Accident Insurance (Monthly Benefit)	75% of annual earnings base divided by 12, but not less than \$370 * per month for full-time Employee (see Notes 2 and 3)
Extended Disability Benefit Insurance (Monthly Benefit)	60% of annual earnings base divided by 12, but not less than \$345 * per month for full-time Employee (see Note 2)

Note 1. If such amount of insurance is not a multiple of \$100, such amount of insurance shall be the next higher multiple of \$100. In any event, the maximum amount of Basic Group Life Insurance shall be determined in accordance with Group Policy No. 14000-G.

Note 2. If such amount of insurance is not a multiple of \$1, such amount of insurance shall be the next higher multiple of \$1.

Note 3. For an Employee hired on or after September 17, 1979, the 75% shall be 60% for any period of disability occurring prior to the day the Employee attains one year of length of service.

\* No minimum amount applies if the Employee is employed in Puerto Rico.

The amounts of insurance for a part-time Employee shall be the amounts obtained by multiplying the ratio

of the Employee's regularly scheduled hours in a week to the number of hours in the standard work week by the amounts of insurance applicable to the Employee in accordance with the foregoing appropriate schedule.

Any increase in the amounts of the Employee's insurance due to a change in monthly base salary, annual earnings base, or salaried position classification shall become effective on the date of such change in the case of a change in monthly base salary or salaried position classification or on the February 1st following the date of such change in the case of a change in annual earnings base, provided the Employee is actively at work on the date of such change or such February 1st. Any decrease in the amounts of the Employee's insurance due to a change in monthly base salary, annual earnings base, or salaried position classification shall become effective on the first day of the calendar month next following the date of such change in the case of a change in monthly base salary or salaried position classification or on the February 1st following the date of such change in the case of a change in annual earnings base, provided the Employee is actively at work on such first day or such February 1st. If the Employee is not actively at work on the date an increase or decrease in the amounts of insurance would otherwise become effective, such increase or decrease shall become effective on the date the Employee returns to active work.

#### Basic Group Life Insurance and Extra Accident Insurance After Age 65

The amounts of Basic Group Life Insurance and Extra Accident Insurance in accordance with the foregoing schedules apply up to and including the end of the month in which the Employee attains age 65.

After the end of the month in which the Employee attains age 65, the amount of Basic Group Life Insur-

ance in force on account of the Employee shall be automatically reduced as set forth below.

If the Employee has credit for 10 or more Years of Participation under Group Policy No. 14000-G on the last day of the calendar month in which the Employee attains age 65, the amount of the Employee's Basic Group Life Insurance in force under Group Policy No. 14000-G on the Employee's 65th birthday, subject to the provisions of the second following paragraph, shall be automatically reduced on the first day of each calendar month following the month in which the Employee attained age 65 by an amount equal to 2% of the amount of the Employee's Basic Group Life Insurance in force on the Employee's 65th birthday, until the amount of the Employee's Basic Group Life Insurance equals 1½% of the amount of Basic Group Life Insurance in force on the Employee's 65th birthday, multiplied by the number of Years of Participation for which the Employee had credit under Group Policy No. 14000-G on the last day of the calendar month in which the Employee attained age 65, or, if later, on the last day of the calendar month in which the Employee's separation from service occurs. Such amount subsequent to the end of the month in which the Employee attained age 65 is referred to as Continuing Life Insurance. If the amount of Continuing Life Insurance after all reductions is not a multiple of \$1, such amount shall be the next higher multiple of \$1. In no event, however, will the amount of the Employee's Basic Group Life Insurance be reduced to less than \$2,500.

If the Employee has credit for less than 10 Years of Participation under Group Policy No. 14000-G on the last day of the calendar month in which the Employee attains age 65, the amount of the Employee's Basic Group Life Insurance in force under Group Policy No. 14000-G on the Employee's 65th birthday, subject to the provisions of the next following paragraph, shall be automatically reduced on the first day of each calendar month follow-

ing the month in which the Employee attained age 65 by an amount equal to 2% of the amount of the Employee's Basic Group Life Insurance in force on the Employee's 65th birthday, until the earliest of 25 months of layoff, 12 months of leave of absence other than for disability, and the Employee's separation from service, and any amount remaining in force shall then be discontinued. However, for an Employee with unbroken length of service on or after January 1, 1979 who attains credit for 10 Years of Participation after the last day of the calendar month in which the Employee attains age 65, the amount of Basic Group Life Insurance in force on the Employee's 65th birthday shall be reduced and continued in accordance with the preceding paragraph.

For an Employee with unbroken length of service on or after January 1, 1979 whose monthly base salary, annual earnings base, or salaried position classification changes after the Employee's 65th birthday and as a result the Employee is entitled to an increased or decreased amount of Basic Group Life Insurance, for the purposes of the provisions of the two preceding paragraphs, the amount of the Employee's Basic Group Life Insurance shall be determined as though such increased or decreased amount of Basic Group Life Insurance was the amount for which the Employee was insured on the Employee's 65th birthday.

The Employee's Extra Accident Insurance, if any, after the end of the month in which the Employee attains age 65, shall be automatically reduced each month to an amount equal to one-half of the Employee's Continuing Life Insurance in force in such month.

If an Employee first becomes insured under Group Policy No. 14000-G at or after age 65, the amounts of Basic Group Life Insurance and Extra Accident Insurance shall be the amounts which would be applicable to the Employee in accordance with the preceding paragraphs if the Employee had been insured on the Employee's 65th birthday for the amount of Basic Group Life Insurance

applicable to the Employee's monthly base salary or annual earnings base on the effective date of insurance in accordance with the foregoing appropriate schedule.

## PART VI. APPLICABLE TO BASIC GROUP LIFE INSURANCE

(See Also Part XII)

### SECTION A. INSURING CLAUSE

If the Employee dies while insured for Basic Group Life Insurance under Group Policy No. 14000-G, the amount of such insurance in force on account of the Employee at the date of the Employee's death shall be paid to the Beneficiary of record under Group Policy No. 14000-G.

### SECTION B. BENEFICIARIES

The Beneficiary is the person or persons designated by the Employee, on a form approved by the Insurance Company and filed with the records maintained by the Employer in connection with the insurance under Group Policy No. 14000-G, to receive upon the Employee's death the amount of Basic Group Life Insurance then payable. The Employee may change the Beneficiary at any time by filing written notice thereof on such a form with the Employer. Consent of the Beneficiary shall not be requisite to any change of Beneficiary. The provisions of the two preceding sentences are subject to any provision or rule of law governing the right to change the beneficiary applicable to an Employee resident in Canada. After receipt of such written notice by the Employer, the change shall relate back and take effect as of the date the Employee signed said written notice of change, whether or not the Employee is living at the time of such receipt, but without prejudice to the Insurance Company on account of any payment made before receipt of such written notice.

If, at the death of the Employee, there shall be more than one designated Beneficiary, then, unless the Employee shall have specified the respective interests of such Beneficiaries, the interests of such Beneficiaries shall be several and equal.

If any designated Beneficiary shall die before the Employee, the rights and interests of such Beneficiary shall thereupon automatically terminate. If, at the death of the Employee, there be no designated Beneficiary as to all or any part of the Life Insurance payable, then the amount of Life Insurance payable for which there is no designated Beneficiary shall be payable to the estate of the Employee, provided, however, that the Insurance Company may, in such case, at its option, pay such amount to any one of the following surviving relatives of the Employee: wife, husband, mother, father, child or children; and payment to any one or more of such surviving relatives shall completely discharge the Insurance Company's liability with respect to the amount of insurance so paid.

The designation by the Employee of a Beneficiary under an individual policy of Life Insurance issued in accordance with the provisions described in Section D of this Part VI and in Section H of Part XIII hereof, other than the Beneficiary of record of the Employee filed with the Employer under the applicable Group Policy, shall effect a change of Beneficiary under such Group Policy to the Beneficiary of record under such individual policy, regardless of whether or not written notice of such change is filed with the Employer.

### SECTION C. TOTAL AND PERMANENT DISABILITY BENEFITS

If the Employee becomes totally and permanently disabled while insured for Basic Group Life Insurance under Group Policy No. 14000-G, the amount of Basic Group

Life Insurance in force on account of the Employee may be payable in instalments as provided in Part XI hereof.

#### SECTION D. PRIVILEGE OF OBTAINING AN INDIVIDUAL POLICY OF LIFE INSURANCE

1. Upon written application made to the Insurance Company within 31 days after

- (i) the date of cessation of the Employee's Basic Group Life Insurance due to termination of employment, or
- (ii) the date of the discontinuance of Group Policy No. 14000-G, provided such date is 5 years or more after the effective date of the Employee's insurance under such Policy, or after the effective date of the Employee's insurance under another group policy issued to the Employer by the Insurance Company, if the Employee was insured under such other group policy immediately prior to the date insurance became effective under Group Policy No. 14000-G, or
- (iii) the date of the cessation, pursuant to item 4 of Part XI hereof, of the payment of instalments to the Employee, provided the Employee does not return to active work with the Employer, or
- (iv) the date of discontinuance of Basic Group Life Insurance pursuant to item 1 of Part XI hereof, provided monthly instalments are not payable pursuant to item 2 of Part XI hereof,

the Employee shall be entitled to have an individual policy of Life Insurance only, without Disability or Accidental Means Death Benefits, issued by the Insurance Company, without evidence of insurability, subject to the following conditions and provisions:

- (A) Such individual policy shall be upon one of the forms then customarily issued by the Insurance Company, except Term Insurance, and
- (B) the premium for such individual policy shall be the premium applicable to the class of risk to which the Employee belongs and to the form and amount of the individual policy at the Employee's attained age at the date of issue of such individual policy, and
- (C) the amount of such individual policy shall be equal to (or at the option of the Employee less than) the amount of the Employee's Basic Group Life Insurance or Death Benefit under Group Policy No. 14000-G, as the case may be, on whichever of the dates specified in items (i), (ii), (iii), and (iv) above is applicable except that if the Employee's Basic Group Life Insurance ceases under the circumstances described in item (ii) above, the amount of such individual policy shall not exceed the amount determined in accordance with the applicable provisions of Group Policy No. 14000-G.

2. Any individual policy of Life Insurance so issued shall become effective not earlier than the expiration of the 31-day period during which application for such individual policy may be made. If, however, the Employee dies during such 31-day period, the Insurance Company shall pay to the Employee's Beneficiary of record under Group Policy No. 14000-G, whether or not the Employee shall have made application for such individual policy, the maximum amount of Life Insurance for which an individual policy could have been issued under the provisions described in this Section D.

## PART VII. APPLICABLE TO SURVIVOR INCOME BENEFIT INSURANCE

(See Also Part XII)

### SECTION A. INSURING CLAUSE

Survivor Income Benefit Insurance is in force under Group Policy No. 22500-G only while the Employee is insured for Extra Accident Insurance under Group Policy No. 14000-G, or until the last day of the calendar month in which the Employee attains age 65 if the Employee retires or is retired under the provisions of the General Motors Retirement Program for Salaried Employees (i) with benefits for total and permanent disability, at the option of the Employer, or under mutually satisfactory conditions, or (ii) with benefits for special early or voluntary retirement, provided that, if the Employee retires voluntarily at or after age 55 but prior to age 60 with less than 85 points, the Employee pays the required contributions. In any case, the Survivor Income Benefit Insurance is in force only while such Employee has at least one dependent who, in the event of the Employee's death while insured under Group Policy No. 22500-G, would qualify as an eligible survivor in one of the Classes as described in Section D of this Part VII, and consists of 2 parts as set forth below.

- (1) A Transition Survivor Income Benefit of \$300 monthly shall be payable for up to 24 months following the death of the Employee, except that the benefit amount shall be \$175 for any month for which an eligible survivor of the deceased Employee is eligible for an unreduced Old-Age Insurance Benefit, a Survivors Insurance Benefit not reduced because of age, or a Disability Insurance Benefit, under the Federal Social Security Act as now in effect or hereafter amended.

For months in which 2 or more eligible survivors share a benefit, each survivor's share is computed as a fraction of the benefit that would be paid to such survivor as a sole survivor, according to her or his own eligibility for Social Security benefits.

In no event shall the maximum amount payable exceed \$300 for any month or \$7,200 in total.

- (2) A Bridge Survivor Income Benefit of \$300 monthly shall be payable after 24 Transition Survivor Income Benefit payments have been made, in the case of a Class A Survivor, or a Class B Survivor, as described in Section D of this Part VII, who was 45 years of age or more but less than 60 years of age on the date of the Employee's death, or whose age, when combined with the Employee's Years of Participation (both of which to be determined to the nearest one-twelfth, and as of the date of the Employee's death), totals 55 or more.

### SECTION B. TRANSITION SURVIVOR INCOME BENEFITS

If the Employee dies while insured for Survivor Income Benefit Insurance under Group Policy No. 22500-G, the Insurance Company shall pay the Transition Survivor Income Benefit commencing on the first day of the calendar month next following the date of the Employee's death. Payment of Transition Survivor Income Benefits will be made to eligible survivors in the first of the Classes, as described in Section D of this Part VII, in which there is an eligible survivor on the first day of the calendar month next following the date of the Employee's death. Such payments shall be made monthly until 24 months' benefits shall have been paid in the aggregate or until there are no eligible survivors remaining in any Class of survivors, whichever first occurs. In no event, however, shall benefits be payable for any period covered by a waiver in accordance with Section E of this Part VII.

A Class of survivors will qualify for benefits when there is no eligible survivor remaining in any of the preceding Classes.

In any case in which the Class A or Class B Survivor waives any right to receive Survivor Income Benefits in accordance with Section E of this Part VII and subsequently dies, any payments of Transition Survivor Income Benefits to a Class C or Class D Survivor shall be determined as if the deceased Class A or Class B Survivor had not waived such benefits. In no event, however, would any such benefit be paid to a Class C or Class D Survivor for any month for which Transition Survivor Income Benefits would have been payable to the Class A or Class B Survivor except for the waiver or for any month subsequent to 24 calendar months after the date of death of the Employee.

No Transition Survivor Income Benefits shall be paid to any person on or after the date such person ceases to be an eligible survivor. In any case, a person's rights to benefits shall cease upon such person's death. If there is more than one eligible survivor in any Class that has qualified for benefits, payment will be made in equal shares to such survivors, except as set forth in item (1) of Section A of this Part VII. If there is no eligible survivor of the Employee in any Class on the first day of the calendar month next following the date of the Employee's death, no payments will be made under the Survivor Income Benefit Insurance.

#### SECTION C. BRIDGE SURVIVOR INCOME BENEFITS

After 24 Transition Survivor Income Benefit payments have been made to a Class A Survivor, or a Class B Survivor, as described in item (2) of Section A of this Part VII, the Bridge Survivor Income Benefit will be payable to such survivor commencing on the first day of the calendar month next following the month for which the 24th Transition Survivor Income Benefit payment is

made and monthly thereafter, provided that (i) no Bridge Survivor Income Benefit shall be payable to a Class A Survivor, or to a Class B Survivor, for any month for which she or he is eligible because of the care of a child to receive Mother's Insurance Benefits or comparable benefits for a father, whether or not called Father's Insurance Benefits, under the Federal Social Security Act as now in effect or hereafter amended, (ii) no Bridge Survivor Income Benefits shall be payable to any survivor for any period covered by a waiver in accordance with Section E of this Part VII, and (iii) no Bridge Survivor Income Benefits shall be payable to any survivor on or after the earliest of the following dates:

- (a) the date of remarriage of the Class A Survivor or Class B Survivor,
- (b) the date of attainment by the Class A Survivor or Class B Survivor of age 62 or such lower age at which full Widow's or Widower's Insurance Benefits or Old-Age Insurance Benefits become payable under the Federal Social Security Act as now in effect or hereafter amended, and
- (c) the date of death of the Class A Survivor or Class B Survivor.

#### SECTION D. CLASSES OF ELIGIBLE SURVIVORS

The Classes of eligible survivors and the order of qualifying for benefits are as follows:

**Class A Survivor:** The widow of a deceased male Employee, but only if she was legally married to him at the time of his death and had been legally married to him for at least one year.

**Class B Survivor:** The widower of a deceased female Employee, but only if he was legally married to her at the time of her death and had been legally married to her for at least one year.

**Class C Survivor:** Any child of the deceased Employee who at the time a Transition Survivor Income Benefit first becomes payable to such child is both unmarried and (i) under 21 years of age, or (ii) at least age 21 but under age 25, or (iii) totally and permanently disabled at any age over 21; provided, however, that a child under (ii) or (iii) must have been legally residing with and dependent upon the Employee at the time of the Employee's death. A child shall cease to be a Class C Survivor on the date of such child's marriage or, if not totally and permanently disabled upon reaching such child's 25th birthday.

**Class D Survivor:** A parent of the deceased Employee for whom the Employee had, during the calendar year preceding the Employee's death, provided at least 50% of the parent's support.

Payment of any Survivor Income Benefit to any Survivor or survivors in any of the above Classes shall forever release and discharge the Insurance Company from any further liability or obligation to the extent of such payment unless the Insurance Company, at the time of making such payment, had knowledge from its records or from written notification received by it that another person or persons was entitled thereto.

No Survivor Income Benefit payable under the Group Policy shall be subject in any manner to assignment, pledge, attachment or encumbrance of any kind, nor subject to the debts or liability of any eligible survivor except as required by applicable law.

#### SECTION E. WAIVER

A Class A or Class B Survivor may waive any right to receive Survivor Income Benefits in order to receive surviving spouse benefits under any pension plan or retirement program to which the Employer has contributed by completing a waiver form furnished by the Employer for that purpose.

If such completed waiver form is received by the Employer on or before the date the survivor's application for Survivor Income Benefits is received by the Employer, the period covered by the waiver shall commence, at the survivor's option, on (1) the first day of the calendar month next following the date of the Employee's death or (2) the first day of a later month designated by such survivor; otherwise, the period covered by a waiver shall commence on the first day of the second month following the month in which the completed waiver form is received by the Employer. In any case, the period covered by any waiver shall terminate as of the last month for which a Survivor Income Benefit would otherwise have been payable or, if earlier, upon termination of the waiver as set forth in the last paragraph of this Section E.

Any month in which a surviving spouse benefit is paid, under any pension plan or retirement program to which the Employer has contributed, during the period that Transition Survivor Income Benefits would otherwise be payable shall be counted as though it were a month in which a Transition Survivor Income Benefit was paid, for the purposes of establishing the total number of Transition Survivor Income Benefits payable pursuant to Section B of this Part VII and when Bridge Survivor Income Benefits could commence to be payable pursuant to Section C of this Part VII.

The Class A or Class B Survivor may terminate the waiver by completing a termination of waiver form furnished by the Employer for that purpose. The period covered by the waiver shall then terminate on the last day of the month following the month in which such completed termination of waiver form is received by the Employer.

## SECTION F. PRIVILEGE OF OBTAINING AN INDIVIDUAL POLICY OF LIFE INSURANCE

1. Upon cessation of the Employee's Survivor Income Benefit Insurance under Group Policy No. 22500-G, provided the Employee has qualified, with respect to the Employee's Basic Group Life Insurance, for the privilege of obtaining an individual policy of Life Insurance, as described in Section D of Part VI hereof, and provided the Employee makes written application within 31 days after the date Survivor Income Benefit Insurance ceases, the amount of such individual policy may, at the option of the Employee, be increased by an amount not to exceed the total amount of Survivor Income Benefit Insurance payments that would have been made if the Employee had died on the date such insurance ceased.

2. In the event of the Employee's death prior to the expiration of the 31-day period during which application for such individual policy may be made, the amount payable pursuant to the provisions of Group Policy No. 22500-G as summarized in this Part VII shall be determined without giving effect to the preceding subsection, and the Insurance Company shall make the Survivor Income Benefit Insurance payments that would have been made had such insurance been in force at the date of the Employee's death.

## PART VIII. APPLICABLE TO EXTRA ACCIDENT INSURANCE

(See Also Part XII)

### SECTION A. INSURING CLAUSE

If, while insured for Extra Accident Insurance under Group Policy No. 14000-G, the Employee sustains accidental bodily injuries, and within one year thereafter shall have suffered loss of life or within 2 years thereafter shall have suffered any other loss as specified in the

Schedule of Losses of this Section A, as a direct result of such bodily injuries independently of all other causes, the Insurance Company shall pay the amount of insurance specified under such loss in said Schedule, provided, however, that in no case shall such payment be made for any loss which is caused wholly or partly, directly or indirectly, by:

- (1) disease or bodily or mental infirmity, or by medical or surgical treatment or diagnosis thereof, or
- (2) any infection, except infection caused by an external visible wound accidentally sustained, or
- (3) hernia, no matter how or when sustained, or
- (4) war or any act of war, or
- (5) intentional self-destruction or intentionally self-inflicted injury, while sane or insane.

If it is determined that any Extra Accident Insurance benefits paid to the Employee under the Group Policy should not have been paid or should have been paid in a lesser amount, the Insurance Company shall be entitled to a refund of the amount of the overpayment. If the Employee fails to repay such amount of overpayment promptly after receipt of written notice from the Insurance Company, the Insurance Company may recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the Employee under the Group Policies.

### SCHEDULE OF LOSSES

1. (A) If the bodily injuries are sustained as the result of an accident while the Employee is not on Company business, the full amount of the Extra Accident Insurance in force on account of the Employee at the date of the accident is payable for any of the following losses: loss of life, total and irrecoverable loss of sight of both

eyes, loss of both hands by severance at or above wrist-joints, loss of both feet by severance at or above ankle-joints, loss of one hand and of one foot by severance at or above wrist- and ankle-joints, respectively, or such loss of one hand or of one foot together with total and irrecoverable loss of sight of one eye. If the bodily injuries are sustained as the result of an accident while the Employee is on Company business, 2 times the full amount of the Extra Accident Insurance in force on account of the Employee at the date of the accident is payable for any of the losses specified in the preceding sentence.

(B) If the bodily injuries are sustained as the result of an accident while the Employee is not on Company business, one-half the amount of the Extra Accident Insurance in force on account of the Employee at the date of the accident is payable for any of the following losses: loss of one hand by severance at or above wrist-joint, loss of one foot by severance at or above ankle-joint, or total and irrecoverable loss of sight of one eye. If the bodily injuries are sustained as the result of an accident while the Employee is on Company business, the full amount of the Extra Accident Insurance in force on account of the Employee at the date of the accident is payable for any of the losses specified in the preceding sentence.

2. If the Employee suffers more than one of the losses set forth above as a result of any one accident, no more than the full amount of the Extra Accident Insurance in force on account of the Employee at the date of the accident is payable in the case of an accident occurring while the Employee is not on Company business, and no more than 2 times such full amount is payable in the case of an accident occurring while the Employee is on Company business.

3. If the Employee has suffered prior to the effective date of the Employee's Extra Accident Insurance, or does thereafter suffer, the loss of one hand by severance at or

above the wrist-joint, or of one foot by severance at or above the ankle-joint, or the total and irrecoverable loss of sight of one eye, the amount of such Extra Accident Insurance shall be the full amount, provided, however, that the amount of such insurance payable for the subsequent loss of one hand or of one foot or the sight of one eye, as specified, shall be the applicable amount specified in subsection 1 (B) of this Schedule of Losses.

#### SECTION B. NOTICE AND PROOF OF CLAIMS

1. Written notice of loss on which claim for Extra Accident Insurance benefits may be based must be given to the Insurance Company within 20 days after the date of such loss. Proof of such loss must be furnished to the Insurance Company within 90 days after the date of such loss.

The Insurance Company, upon receipt of the required notice, will furnish such forms as are usually furnished by it for filing proofs of claim. If such forms are not received by the claimant within 15 days after the Insurance Company receives such notice, the claimant shall be deemed to have complied with the requirements as to proof of claim upon submitting, within the time specified in the preceding paragraph for filing proofs of claim, written proof covering the occurrence, character and extent of the loss for which claim is made.

Failure to furnish notice or proof within the time provided above shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible.

2. The Insurance Company, at its own expense, shall have the right and opportunity to have such medical examinations of the person of the Employee, as often as it may reasonably require, made by a physician or physicians designated by it while Extra Accident Insurance

benefits are being claimed under Group Policy No. 14000-G, and also the right to have an autopsy made in case of death, where it is not forbidden by law.

3. No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of 60 days after proof of claim has been filed in accordance with the requirements set forth in item 1 of this Section B, nor shall such action be brought at all unless brought within 3 years from the expiration of the time within which proof of claim is required.

#### SECTION C.—PAYMENT OF CLAIMS

The Extra Accident Insurance benefits will be paid immediately after receipt of due proof. Benefits for loss of life are payable to the Beneficiary of record under Group Policy No. 14000-G, if surviving the Employee, otherwise to the estate of the Employee. All other Extra Accident Insurance benefits are payable to the Employee.

### PART IX. APPLICABLE TO SICKNESS AND ACCIDENT INSURANCE

(See Also Part XII)

#### SECTION A. INSURING CLAUSE

If, while insured for Sickness and Accident Insurance under the Group Policy, the Employee becomes wholly and continuously disabled as a result of any injury or any sickness so as to be prevented thereby from performing any and every duty of the Employee's occupation, and during the period of such disability is under treatment therefor by a physician legally licensed to practice medicine, the amount of Monthly Benefit then in force on account of the Employee shall be paid to the Employee each month during the period the Employee is so disabled and under such treatment, provided, however, that (1) in no case shall such benefits be payable for the waiting period

specified below, and (2) in no case shall such benefits be payable for more than the maximum benefit period specified below, for any one continuous period of disability whether from one or more causes, or for successive periods of disability due to the same or related cause or causes. For the purposes of this paragraph, an Employee who becomes wholly and continuously disabled as a result of undergoing surgery for sterilization purposes, or an Employee who is confined as a registered bed patient in a legally constituted hospital for the purpose of undergoing testing to determine the Employee's suitability to be a donor for an organ or tissue transplant shall be considered for benefits on the same basis as if the Employee were disabled as a result of sickness.

The waiting period shall be the first 7 days of disability.

The maximum benefit period referred to above is equal, on a time-for-time basis, to the period of time from the Employee's most recent date of hire, as determined by the Employer, through and including the first day of disability or, if longer, the period equal to the Employee's credit for Years of Participation on such first day of disability, but in either case not more than 12 months. However, if such Employee is confined as a registered bed patient in a legally constituted hospital or is receiving payments because of employment with the Employer under any Workers Compensation Law or Act or any Occupational Disease Law or Act for the same disability at the date of expiration of the maximum period for which the Employee is entitled to receive Monthly Benefits, and such benefits were payable for less than 12 months, benefits shall continue to be payable while the Employee continues to be so confined or while the Employee receives such payments, but in no case beyond the end of such 12-month period.

If there are 3 months or more between 2 periods of disability, and the Employee returned to work with the

Employer for at least one day in the intervening period, the second period of disability shall not be considered as being due to the same or related cause or causes as the first disability.

For the purpose of determining the period for which benefits are payable in accordance with item (2) of the first paragraph of this Section A, if salary payments under the Employer's Salary Continuation Plan have been paid or are payable with respect to a prior period of disability due to the same or related cause or causes, but separated by less than 3 months from the second period of disability, the period for which such salary payments have been paid or are payable shall be deemed to be a period with respect to which Sickness and Accident Insurance Monthly Benefits were paid under the Group Policy.

The amount of Sickness and Accident Insurance Monthly Benefits payable on account of any period of disability, subsequent to the applicable waiting period specified above, shall be reduced by the amount of any weekly benefits which the Employee receives or is entitled to receive on account of such period, because of employment with the Employer, from any other fund, other insurance or other arrangement, provided or established in conformity with any state or other governmental law providing for disability or cash sickness benefits.

In the event of a disability arising out of, or in the course of, any employment for wage or profit for which the Employee is entitled to any benefits for time lost from work under any Workers Compensation Law or Act or any Occupational Disease Law or Act, the amount of any Monthly Benefits payable under the Group Policy on account of such disability shall be reduced by the amount of such benefits. No reduction shall be made for any payments under such laws specifically for hospitalization or medical expense, or specific allowances for loss, or 100% loss of use, of a body member or for disfigure-

ments, or permanent partial disability payments for a work-related disability unrelated to the disability for which benefits are payable under the Group Policy. Further, no reduction shall be made for any benefits for total disability due to pneumoconiosis as defined on September 21, 1973 under the Federal Black Lung Benefits Act of 1972.

The amount of any Monthly Benefits payable under the Group Policy on account of any period of disability shall be reduced by the amount of any unemployment benefits to which the Employee is entitled for the same period of disability under any Unemployment Compensation Law.

If it is determined that any Sickness and Accident Insurance benefits paid to the Employee under the Group Policy should not have been paid or should have been paid in a lesser amount, the Insurance Company shall be entitled to a refund of the amount of the overpayment. If the Employee fails to repay such amount of overpayment promptly after receipt of written notice from the Insurance Company, the Insurance Company may recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the Employee under the Group Policies.

**REINSTATEMENT FOR CERTAIN EMPLOYEES DISABLED WHILE ON NON-DISABILITY LEAVE**—If an Employee is granted a leave of absence other than for disability because of a clinically anticipated disability based on the natural course of the Employee's diagnosed condition, Sickness and Accident Insurance under the Group Policy which may have ceased in accordance with the provisions of exception (B) of item 1 of Part XII hereof during the period of such leave shall be reinstated, provided the Employee is insured for Basic Group Life Insurance under Group Policy No. 14000-G as of the date the Employee presents medical certification from the Employee's per-

sonal physician, satisfactory to the Insurance Company, that the Employee is totally disabled and shall remain in force on the same basis as set forth in this Part IX.

#### SECTION B. NOTICE AND PROOF OF CLAIMS

1. Written notice of injury or sickness on which claim for Sickness and Accident Insurance Monthly Benefits may be based must be given to the Insurance Company within 20 days after the date of the accident causing such injury or the commencement of disability resulting from such sickness. Proof of such injury or sickness must be furnished to the Insurance Company within 90 days after the termination of the period for which Monthly Benefits are payable under the Group Policy.

The Insurance Company, upon receipt of the required notice, will furnish such forms as are usually furnished by it for filing proofs of claim. If such forms are not received by the claimant within 15 days after the Insurance Company receives such notice, the claimant shall be deemed to have complied with the requirements as to proof of claim upon submitting, within the time specified in the preceding paragraph for filing proofs of claim, written proof covering the occurrence, character and extent of the disability for which claim is made.

Failure to furnish notice or proof within the time provided above shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible.

2. The Insurance Company, at its own expense, shall have the right to have such medical examinations of the person of an Employee who is eligible to receive Sickness and Accident Insurance Monthly Benefits, as it may reasonably require, made by a physician or physicians designated by it. An Employee whose residence is more than 40 miles one way from the office where any such ex-

amination is to be made will be reimbursed, upon request, at the rate of 17 cents per mile for miles actually driven from such residence to such office and back, using the most direct route available.

3. No action at law or in equity shall be brought to recover on the Group Policy prior to the expiration of 60 days after proof of claim has been filed in accordance with the requirements set forth in item 1 of this Section B, nor shall such action be brought at all unless brought within 3 years from the expiration of the time within which proof of claim is required.

#### SECTION C. PAYMENT OF CLAIMS

Subject to due proof of claim, the Sickness and Accident Insurance Monthly Benefits will be paid to the Employee each month during any period of disability for which such benefits are payable, and any balance remaining unpaid after termination of such period will be paid immediately upon receipt of proof. Any such benefits due for the whole of a pay period shall be the Monthly Benefit divided by the number of pay periods in the month. Any such benefits due for periods other than the whole of the Employee's normal pay period shall be such a proportion of the Monthly Benefit as the number of working days that the Employee is disabled in such pay period bears to the entire number of working days in that month. Working days, as used in the preceding sentence, shall include only those in the base work week.

If such disability is due to or accompanied by mental incapacity, the whole or any part of such Monthly Benefits may, at the option of the Insurance Company, be paid to the Beneficiary of record under Group Policy No. 14000-G or to any other person or institution then in the judgment of the Insurance Company contributing toward or providing for the care or maintenance of the Employee.

The Employee may waive irrevocably any right to receive Sickness and Accident Insurance Monthly Benefits in order to receive benefits under any pension plan or retirement program to which the Employer has contributed by completing a waiver form furnished by the Employer for that purpose. No Sickness and Accident Insurance Monthly Benefits shall be payable for any period of disability covered by such waiver.

## PART X. APPLICABLE TO EXTENDED DISABILITY BENEFIT INSURANCE

(See Also Part XII)

### SECTION A. INSURING CLAUSE

If, on the date of expiration of the maximum number of months for which Sickness and Accident Insurance Monthly Benefits are payable, or on the date of expiration of salary payments under the Employer's Salary Continuation Plan, whichever is later, the Employee is insured for Extended Disability Benefit Insurance under the Group Policy and is totally disabled as defined in the next paragraph, the amount of Extended Disability Benefit Insurance Monthly Benefit then in force on account of the Employee shall be paid to the Employee each month during the period the Employee is so disabled, as set forth herein.

An Employee shall be deemed to be totally disabled only if the Employee is not engaged in regular employment or occupation for remuneration or profit and, on the basis of medical evidence satisfactory to the Insurance Company, the Employee is found to be wholly prevented, as a result of bodily injury or disease, either occupational or non-occupational in cause, from engaging in regular employment or occupation, for remuneration or profit, with the Employer at the location where the Employee last worked.

If, while insured for Basic Group Life Insurance but not for Extended Disability Benefit Insurance and while on layoff-inactive status as determined by the Employer, an Employee who has at least one year of recognized length of service as of the first day of layoff, and who is entitled to benefits under the Employer's Layoff Benefit Plan or payments under the Employer's Separation Allowance Plan, becomes totally disabled as defined in the preceding paragraph, Extended Disability Benefit Insurance shall be reinstated on the date of expiration of the maximum period for which the Employee is entitled to such benefits or payments and Monthly Benefits shall be payable on account of such disability subject to the provisions of this Part X.

### SECTION B. AMOUNT OF BENEFIT

The Monthly Benefit is the applicable amount shown in the Schedule of Insurance in Part V hereof, reduced by an amount equal to the monthly equivalent of the total of the following benefits for which the Employee is eligible:

- (i) Part A benefits and Part B supplementary benefits under the General Motors Retirement Program for Salaried Employees or any benefits under any other pension plan or retirement program then in effect to which the Employer has contributed;
- (ii) benefits on account of time lost from work under any Workers Compensation Law or Act or any other law or act providing benefits for occupational injury or disease, including lump-sum settlements, but excluding specific allowance for loss, or 100% loss of use, of a body member, or permanent partial disability payments for a work-related disability unrelated to the disability for which benefits are payable under the Group Policy, and excluding benefits

for total disability due to pneumoconiosis as defined on September 21, 1973 under the Federal Black Lung Benefits Act of 1972;

- (iii) Disability or Old-Age Insurance Benefits (primary insurance amount only) to which the Employee is entitled under the Federal Social Security Act or any future legislation providing similar benefits, except old-age benefits reduced because of the age at which received;
- (iv) benefits under any state or Federal law for time lost from work because of disability.

For purposes of such reduction, a Monthly Benefit shall be deemed equal to 4.33 weekly benefits.

Any benefits described in item (i), (ii), (iii), or (iv) above awarded retroactively shall be treated as having been received by the Employee during the entire time period for which such benefits were payable and any overpayments of Extended Disability Benefits shall be calculated accordingly.

Lump-sum settlements under state Workers Compensation Laws result in reductions equal to the monthly equivalent of the amount of the Workers Compensation benefit to which the Employee would have been entitled under the applicable law had there been no lump-sum payment, but not to exceed in total the amount of the settlement. The amount of such settlement shall be allocated to days of disability for which compensation has not previously been paid, in chronological order until such amount has been fully allocated, at the rate of one-seventh of the weekly Workers Compensation benefit which would have been applicable under the state law if the claim had been allowed and if there had been no lump-sum settlement.

Any increase in the amount of benefits described in item (i), (ii), (iii), or (iv) above that is effective subsequent to the first day for which Extended Disability

Benefits are payable shall not increase the amount of reduction in Extended Disability Benefits on account of such benefits, unless the amount of increase in any such benefit represents an adjustment in the original determination of the amount of such benefit.

Extended Disability Benefit computations presume eligibility for Social Security Disability Insurance Benefits and for disability benefits under any pension plan or retirement program then in effect to which the Employer has contributed, excluding any Part B primary benefits under the General Motors Retirement Program for Salaried Employees; however, the presumption of such pension plan or retirement program disability benefits shall not be made with respect to any Extended Disability Benefit payments due for the 12-month period immediately following the date of expiration of the maximum number of months for which the Employee is entitled to receive Sickness and Accident Insurance Monthly Benefits or the date of expiration of salary payments under the Employer's Salary Continuation Plan, whichever is later, or the date of expiration of benefits under the Employer's Layoff Benefit Plan or payments under the Employer's Separation Allowance Plan.

Amounts deducted from Extended Disability Benefits on the basis set forth in the preceding paragraph are paid upon presentation of satisfactory evidence that Social Security Disability Insurance Benefits or pension plan or retirement program disability benefits were applied for and denied; provided, however, that a reduction in Extended Disability Benefits is made in an amount equal to Social Security Disability Insurance Benefits that would have been payable except for refusal to accept vocational rehabilitation services or failure to submit the required medical evidence.

Benefits payable for less than a full calendar month are prorated on the basis of the ratio of calendar days of eligibility to total calendar days in the month.

The Insurance Company may require the Employee to certify or furnish verification of the amounts of the Employee's income from sources listed above.

If it is determined that any Extended Disability Benefits paid to the Employee under the Group Policy should not have been paid or should have been paid in a lesser amount, the Insurance Company shall be entitled to a refund of the amount of the overpayment. If the Employee fails to repay such amount of overpayment promptly after receipt of written notice from the Insurance Company, the Insurance Company may recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the Employee under the Group Policies.

#### SECTION C.

##### COMMENCEMENT AND DURATION OF BENEFITS

Extended Disability Benefits shall be payable to an eligible Employee for a period commencing the day following the last day of disability included within the period for the maximum number of Sickness and Accident Insurance Monthly Benefits, including months in which such Sickness and Accident Insurance benefits were partially or wholly offset because of receipt of Workers Compensation benefits, or expiration of salary payments under the Employer's Salary Continuation Plan, whichever is later, or expiration of benefits under the Employer's Layoff Benefit Plan or payments under the Employer's Separation Allowance Plan.

If the Employee has 10 or more Years of Participation as of the day on which disability commenced, the maximum period during which Extended Disability Benefits may be payable shall be the number of months commencing with the month in which the date occurs of the expiration of the maximum number of months for which the Employee is entitled to receive Sickness and Accident

Insurance Monthly Benefits, Salary Continuation payments, Layoff Benefits, or Separation Allowance payments and terminating with the earliest of (i) the date of death; (ii) the end of the month in which the Employee attains age 65 (provided, however, that for an Employee with unbroken length of service on or after January 1, 1979 who becomes disabled at or after age 63 and subsequently becomes eligible for Extended Disability Benefits, such benefits will be payable for up to 12 months, but in no event beyond the end of the month in which the Employee attains age 70); (iii) the time that the Employee no longer satisfies the disability requirement; and (iv) in the case of an Employee who becomes totally disabled on or after January 1, 1981, the expiration of the period ending with December 31st of the calendar year following the calendar year in which the Employee's disability commenced, provided that, pursuant to the provisions of the Group Policy, such period will be extended for successive one-year periods by written notice and payment of the appropriate premium by the Policyholder to the Insurance Company.

If the Employee has less than 10 Years of Participation as of the day on which disability commenced, the maximum period during which Extended Disability Benefits may be payable shall be the number of months by which the Employee's Years of Participation at commencement of disability exceed the maximum number of months for which the Employee is entitled to receive Sickness and Accident Insurance Monthly Benefits, Salary Continuation payments, Layoff Benefits, or Separation Allowance payments, but in no event beyond the earliest of (i) the date of death; (ii) the end of the month in which the Employee attains age 65 (provided, however, that for an Employee with unbroken length of service on or after January 1, 1979 who becomes disabled at or after age 63 and subsequently becomes eligible for Extended Disability Benefits, such benefits will be payable for up to 12

months, but in no event beyond the end of the month in which the Employee attains age 70); (iii) the time that the Employee no longer satisfies the disability requirement; and (iv) in the case of an Employee who becomes totally disabled on or after January 1, 1981, the expiration of the period ending with December 31st of the calendar year following the calendar year in which the Employee's disability commenced, provided that, pursuant to the provisions of the Group Policy, such period will be extended for successive one-year periods by written notice and payment of the appropriate premium by the Policyholder to the Insurance Company.

If the Employee's return to work with the Employer does not qualify the Employee for a new period of Sick-ness and Accident Insurance Monthly Benefits or Salary Continuation payments, or if the Employee engages in some gainful occupation or employment other than one for which the Employee is reasonably qualified by education, training or experience, the Employee's satisfying of the disability requirement shall not be deemed to end, but the Employee's Extended Disability Benefits shall be suspended for the period of such return to work or the period the Employee engages in such occupation or employment.

If the Employee fails to satisfy the disability requirement and, within 2 weeks of the time that the Employee no longer satisfied the disability requirement and before the Employee returns to work with the Employer, again becomes disabled so as to satisfy the disability requirement, Extended Disability Benefits shall again be payable to the Employee commencing on the date the Employee becomes so disabled.

For purposes of applying the maximum period of monthly Extended Disability Benefits, a month in which such benefits are partially or wholly offset by benefit payments from sources listed in terms (i) through (iv)

of Section B of this Part X, suspended in accordance with the fourth paragraph of this Section C, or not paid in accordance with the preceding paragraph, is counted as a full month. Fractions of the first and last month are counted as fractions of a month.

The cumulative total number of months during any previous periods of eligibility for Extended Disability Benefits, regardless of whether for the same or related disabling condition, reduces the maximum number of Monthly Benefit payments for which the Employee is otherwise eligible when Extended Disability Benefits again commence.

If disability is due to or accompanied by mental incapacity, the whole or any part of Extended Disability Benefits may, at the option of the Insurance Company, be paid to the Beneficiary of record under Group Policy No. 14000-G or to any other person or institution then in the judgment of the Insurance Company contributing toward or providing for the care or maintenance of the Employee.

#### SECTION D. REHABILITATION

There is no ineligibility for Extended Disability Benefits because of work which is determined to be primarily for training under a recognized program of vocational rehabilitation.

#### SECTION E. PROOF OF DISABILITY

The Insurance Company may require the Employee, as a condition of eligibility, to submit to examinations by a physician or physicians designated by it for the purpose of determining the Employee's initial or continuing disability. An Employee whose residence is more than 40 miles one way from the office where any such examination is to be made will be reimbursed, upon request, at the rate of 17 cents per mile for miles actually driven

from such residence to such office and back, using the most direct route available.

#### SECTION F. ADDITIONAL MONTHLY BENEFIT

For months commencing on or after October 1, 1979, an Employee who is eligible for Extended Disability Benefits and is age 65 or older, or is under age 65 and enrolled in the medical insurance plan (Medicare—Part B) under the Federal Social Security Act, shall be paid an additional monthly Extended Disability Benefit of \$8.70, increased on October 1, 1980 to \$9.20, and on October 1, 1981 to \$9.70, each month, provided the Employee is not receiving a similar monthly special benefit under any pension plan or retirement program to which the Employer has contributed. In no event shall payment of such additional monthly Extended Disability Benefit be made for any month prior to the month in which the Employee attains age 65, unless the Employer receives application from the Employee on a form provided for this purpose, in which case such payment shall be made effective commencing with the month in which such Employee enrolls. Not more than one such payment shall be made to an Employee for any one month.

#### PART XI. TOTAL AND PERMANENT DISABILITY BENEFITS

(See Also Parts VI and XII)

1. For an Employee with unbroken length of service on or after January 1, 1979 who has credit for less than 10 Years of Participation on the last day of the calendar month in which the Employee becomes totally and permanently disabled, as defined in the next paragraph, while insured for Extended Disability Benefit Insurance under the Group Policy, and on the date of expiration of the maximum period for which Extended Disability Benefits are payable is both insured for Basic Group Life Insurance under Group Policy No. 14000-G and so disabled,

and provided the Employee submits proof satisfactory to the Insurance Company that total and permanent disability commenced prior to the end of the calendar month in which the Employee's 70th birthday occurs, and provided the Employee so elects, the Insurance Company shall discontinue the Basic Group Life Insurance on the life of said Employee and will commence to pay to the Employee, in lieu of the payment of Basic Group Life Insurance at the Employee's death, monthly instalments in an amount equal to the amount of Extended Disability Benefit determined in accordance with Section B of Part X hereof as of the last month in the maximum period for which Extended Disability Benefits are payable, and will continue to pay such instalments during the period of total and permanent disability until the aggregate of such instalments equals the smaller of (i) the amount of the Employee's Basic Group Life Insurance in force under Group Policy No. 14000-G on the date of expiration of the maximum period for which Extended Disability Benefits were payable and (ii) \$100,000, or, in the case of an Employee who becomes totally and permanently disabled on or after January 1, 1981, until the expiration of the period ending with December 31st of the calendar year following the calendar year in which the Employee's disability commenced, if earlier, provided that, pursuant to the provisions of the Group Policy, such period will be extended for successive one-year periods by written notice and payment of the appropriate premium by the Policyholder to the Insurance Company.

An Employee shall be deemed to be totally and permanently disabled only if the Employee is not engaged in regular employment or occupation for remuneration or profit and, on the basis of medical evidence satisfactory to the Insurance Company, the Employee is found to be wholly and permanently prevented, as a result of bodily injury or disease, either occupational or non-occupational in cause, from engaging in regular employment or occu-

pation, for remuneration or profit, with the Employer at the location where the Employee last worked, but excluding disabilities resulting from service in the armed forces of any country unless the Employee becomes totally and permanently disabled after the Employee has accumulated at least 10 years of recognized length of service following separation from service in the armed forces.

The first such instalment shall be payable on the day following the date of expiration of the maximum number of months for which Extended Disability Benefits are payable to the Employee under any Plan to which the Employer contributes.

2. No monthly instalments shall be payable, and the provisions set forth in Section D of Part VI hereof shall apply to the Employee,

- (i) with respect to the excess, if any, of the amount of the Employee's Basic Group Life Insurance discontinued on account of total and permanent disability over \$100,000, or
- (ii) with respect to any amount of the Employee's Basic Group Life Insurance, if, on the date of expiration of the maximum period for which Extended Disability Benefits are payable, the amount of the Extended Disability Benefit determined in accordance with Section B of Part X hereof as of the last month in such maximum period is zero.

3. If the Employee dies during the period of total and permanent disability, an amount equal to the aggregate of the instalments remaining unpaid shall be paid as a Death Benefit to the Beneficiary of record under Group Policy No. 14000-G.

4. If the Employee ceases to be so disabled or fails to submit any required proof, the monthly instalments shall automatically and immediately cease. If the Employee re-

turns to work with the Employer, such Employee shall be eligible for insurance in accordance with Part III hereof. If the Employee does not return to work with the Employer, the provisions set forth in Section D of Part VI hereof shall apply to such employee.

5. If such disability is due to or accompanied by mental incapacity, the whole or any part of such instalments may, at the option of the Insurance Company, be paid to the Beneficiary of record under Group Policy No. 14000-G or to any other person or institution then in the judgment of the Insurance Company contributing toward or providing for the care or maintenance of the Employee.

6. Notwithstanding that proof of total and permanent disability may have been accepted by the Insurance Company as satisfactory, the Employee on request from the Insurance Company shall furnish due proof of the continuance of such disability, and shall submit to physical examination at reasonable intervals by physicians designated by the Insurance Company. An employee whose residence is more than 40 miles one way from the office where any such examination is to be made will be reimbursed, upon request, at the rate of 17 cents per mile for miles actually driven from such residence to such office and back, using the most direct route available.

7. If it is determined that any Total and Permanent Disability Benefits paid to the Employee under the Group Policy should not have been paid or should have been paid in a lesser amount, the Insurance Company shall be entitled to a refund of the amount of the overpayment. If the Employee fails to repay such amount of the overpayment promptly after receipt of written notice from the Insurance Company, the Insurance Company may recover the amount of the overpayment by making an appropriate deduction or deductions from any future benefit payment or payments payable to the Employee under the Group Policies.

## PART XII. CESSATION OF INSURANCE

1 The Employee's insurance shall automatically cease on the date of termination of the Employee's employment because of quit or discharge, otherwise on the last day of the calendar month in which termination of employment occurs.

For the purposes of insurance, "termination of employment" means cessation of active work as an Employee as defined in Part I hereof, with the following exceptions:

- (A) In the case of absence of the Employee from active work because the Employee is totally disabled, the Employee's employment, for the purposes of the Employee's insurance under the Group Policies, will be deemed to continue for any period during which the Employee is entitled to receive Sickness and Accident Insurance benefits under the Group Policy or salary payments under the Employer's Salary Continuation Plan, or is totally and continuously disabled and on an approved disability leave of absence which commenced while the Employee was insured for Sickness and Accident Insurance under the Group Policy, or was insured for Basic Group Life Insurance under Group Policy No. 14000-G and was entitled to receive salary payments under the Employer's Salary Continuation Plan, but not to exceed the period equal to the Employee's Years of Participation as of the first day of disability, except that if an Employee's disability leave of absence is canceled by the Employer, the Employee's employment, for the purposes of the Employee's insurance under the Group Policies, will be deemed to continue for any period during which the Employee is entitled to receive Extended Disability Benefits under the Group Policy subsequent to such cancellation; however, if the Employee continues to be disabled after the expiration of such periods, the Employee's employment, for the purposes of

the Employee's basic Group Life and Extra Accident Insurance under Group Policy No. 14000-G and Survivor Income Benefit Insurance under Group Policy No. 22500-G, will be deemed to continue during the Employee's period of continuing total disability but not beyond age 65, and if such Employee had credit for less than 10 Years of Participation under the Group Policy as of the first day of disability, in no case beyond the later of

- (a) the expiration of a period of one year following the end of the calendar month in which the Employee became disabled, and
  - (b) the last day of the calendar month in which the Employee's 65th birthday occurs, or the expiration of a period following the end of the calendar month in which the Employee became disabled equal to the number of Years of Participation credited to the Employee as of the first day of disability, whichever first occurs;
- (B) in the case of absence of the Employee from active work because of layoff or leave of absence other than for disability, the Employee's employment, for the purposes of the Employee's Sickness and Accident and Extended Disability Benefit Insurance under the Group Policy, will be deemed to continue during such absence, but in no case beyond the expiration of a period of one month following the end of the calendar month during which the Employee last worked prior to such layoff or leave of absence, and for the purposes of the Employee's Basic Group Life, Extra Accident, and Survivor Income Benefit Insurance under the Group Policies, will be deemed to continue during such absence, but in no case beyond the expiration of a period of (i) 25 months following the end of the calendar month during which the Employee last worked prior

to such layoff, and (ii) 12 months following the end of the calendar month during which the Employee last worked prior to such leave of absence; and

- (C) in certain other circumstances specified in the Group Policies, the Employee's employment may be deemed to continue after such cessation subject to the terms of the Group Policies. These circumstances include cessation of active work by the Employee prior to the Employee's 60th birthday, provided the Employee then meets the requirements specified in the Group Policies.

The Employee will be totally disabled, for the purposes of this Part XII, if, while insured under the Group Policies, the Employee becomes wholly and continuously disabled as a result of any injury or any sickness so as to be prevented thereby from performing any and every duty of the Employee's occupation, and during the period of such disability such Employee shall have been under treatment therefor by a physician legally licensed to practice medicine, subject to the following conditions:

- (i) Initial proof, in writing, of total disability must be submitted to the Insurance Company by or on behalf of the Employee within 3 months after the date of commencement of the total disability and at any time thereafter on demand from the Insurance Company further satisfactory proof, in writing, must be submitted to the Insurance Company that the total disability continues.
- (ii) Whenever proof of the Employee's total disability is submitted, the Insurance Company, at its own expense, shall have the right and opportunity to have the Employee examined by a physician designated by it.
- (iii) If the Employee ceases to be so totally disabled or fails to submit any required proof within the

time prescribed therefor, the Employee's rights under the exception (A) specified above shall automatically and immediately cease and unless the Employee returns to active work with the Employer or meets the requirements for further continuance of such insurance under the other provisions of the Group Policies referred to in exception (C) above, the Employee's termination of employment shall be deemed to have occurred on the earlier of (a) the date of such cessation of total disability, and (b) failure to submit the required proof.

2. The Employee's insurance under any Group Policy shall automatically cease on the date of discontinuance of said Group Policy.

3. If the Employee fails to make any contribution required by the Employer to the cost of the Employee's insurance under the Group Policies, such insurance shall automatically cease on the last day of the calendar month preceding the calendar month for which such contribution was due.

4. The Employee's Sickness and Accident Insurance shall automatically cease on the later of (a) the date of expiration of the maximum number of months for which Sickness and Accident Insurance Monthly Benefits are payable under the Group Policy on account of the Employee's disability and (b) the earliest of the date of expiration of the Employee's approved disability leave of absence, the date the Employee ceases to be totally disabled, and the day immediately preceding the date the Employee's retirement becomes effective. It may be reinstated only if and when the Employee returns to active work for the Employer, except as otherwise specifically provided in Section A of Part IX hereof.

5. The Employee's Extended Disability Benefit Insurance shall automatically cease on the earliest of the date

of expiration of the maximum number of months for which monthly Extended Disability Benefits are payable under the Group Policy on account of the Employee's disability, the date the employee ceases to be totally disabled, the day immediately preceding the date the Employee's retirement becomes effective, and the date of discontinuance of the provisions for such insurance under the Group Policy. It may be reinstated only if and when the Employee returns to active work for the Employer, except as otherwise specifically provided in Section A of Part X hereof.

6. The Employee's Extra Accident Insurance shall cease on the date of discontinuance of the Employee's Basic Group Life Insurance in accordance with the provisions of Part XI hereof. The Extra Accident Insurance shall automatically cease on the last day of the calendar month in which the 65th birthday of the Employee occurs, unless the Employee is then actively at work with the Employer or meets the requirements for further continuance of such insurance under other provisions of Group Policy No. 14000-G, but, in any event, on the last day of the calendar month in which the Employee's 70th birthday occurs.

7. The Employee's Survivor Income Benefit Insurance shall automatically cease on whichever of the following dates is earliest:

(a) The date of cessation of the Employee's Extra Accident Insurance under Group Policy No. 14000-G, except in the case of such cessation in accordance with item 1 of this Part XII due to the Employee's retirement under the circumstances specified in the following item (b).

(b) The last day of the calendar month in which the Employee attains age 65, in the case of the Employee's retirement under the total and permanent disability provisions of any pension plan or retirement program to which the Employer has contributed, or under the provisions of the General Motors Retirement Program for

Salaried Employees with benefits at the option of the Employer, under mutually satisfactory conditions, or for special early or voluntary retirement, provided that, if the Employee retires voluntarily at or after age 55 but prior to age 60 with less than 85 points, the Employee pays the required contributions.

(c) The last day of the month in which the Employee attains automatic retirement age, as determined by the Employer.

(d) The date the Employee ceases to have a dependent who could qualify as an eligible survivor.

### PART XIII. APPLICABLE TO OPTIONAL GROUP LIFE INSURANCE

#### SECTION A. INSURING CLAUSE

If the Employee dies while insured for Optional Group Life Insurance under Group Policy No. 23600-G, the amount of such insurance in force on account of the Employee at the date of the Employee's death shall be paid to the Beneficiary of record under Group Policy No. 23600-G.

#### SECTION B. ELIGIBILITY

An Employee, as defined in Part I hereof, who is insured for Basic Group Life Insurance under Group Policy No. 14000-G, is eligible for Optional Group Life Insurance on the first day of the calendar month immediately following the date of completion of 6 months of service as determined by the Employer. Such first day is the Employer's eligibility date.

#### SECTION C. ENROLLMENT AND EFFECTIVE DATE

An Employee may elect to enroll for Optional Group Life Insurance by completing an enrollment election form approved by the Insurance Company.

The Employee may enroll for:

Schedule I		Schedule II
A flat amount of	OR	An amount equal to
\$ 5,000		1, 2, 3, 4, or 5
\$10,000		times the
or		Employee's annual
\$15,000		base salary *

\* Annual base salary means 12 times the Employee's monthly base salary, or the Employee's annual earnings base if the Employee is compensated wholly or partially on a commission basis, including any premium for 7-day operations but excluding any overtime, night shift premium, or cost-of-living allowance. If, 1, 2, 3, 4, or 5 times annual base salary is not a multiple of \$100, the amount of insurance shall be the next higher multiple of \$100. In any event, the maximum amount of insurance shall be determined in accordance with Group Policy No. 23600-G (in the case of an Employee compensated wholly or partially on a commission basis, the maximum amount of insurance is \$170,000).

If the Employee enrolls on or before the Employee's eligibility date, the insurance becomes effective on the date of eligibility, provided the Employee is then actively at work. If the Employee enrolls during the 31-day period following the Employee's eligibility date, the insurance becomes effective on the date the Employee enrolls, provided the Employee is then actively at work.

If the Employee is not actively at work on the date the insurance would otherwise become effective, the insurance will become effective on the next following day on which the Employee is actively at work, provided that date is not more than 24 months later or, if such date is more than 24 months later, the Employee has not then broken recognized length of service as defined by the Employer.

If the Employee does not enroll on or prior to the 31st day following the Employee's eligibility date, or if the Employee becomes insured under Group Policy No. 23600-G and later decides to elect a higher amount of insurance set forth in Schedule I or Schedule II, the Employee may

become insured initially, or for such higher amount of insurance, only by furnishing one of the following:

- (1) evidence satisfactory to the Insurance Company of the Employee's good health, or
- (2) evidence satisfactory to the Insurance Company that the Employee has married or acquired children by birth or adoption during the 31-day period immediately prior to such enrollment.

Such evidence required in items (1) and (2) above must be furnished to the Insurance Company by the Employee, at the Employee's own expense, on a form and in a manner approved by the Insurance Company.

If the required evidence is accepted as satisfactory by the Insurance Company, the Employee will become insured initially, or for such higher amount of insurance, on the first day of the calendar month following the date such evidence is accepted as satisfactory, provided the Employee is then actively at work, otherwise on the next following day on which the Employee is actively at work, and provided further that, if the Employee is to become insured initially, or for such higher amount of insurance, in accordance with item (2) above, the change in status is still in existence.

If the Employee becomes insured under Group Policy No. 23600-G and later decides to elect a lower amount of insurance set forth in Schedule I or Schedule II, the Employee will become insured for such lower amount of insurance on the first day of the calendar month following the month for which the required monthly contribution was paid for the higher amount, whether or not the Employee is then actively at work.

#### SECTION D. CONTRIBUTIONS

Employee contributions to the cost of Optional Group Life Insurance are required for such insurance to be in force

on account of the Employee. The required monthly contribution for each \$1,000 of Optional Group Life Insurance is as set forth in the following schedule, which is subject to change.

Employee's Age	Monthly Contribution	
	Prior to Jan. 1, 1980	On and After Jan. 1, 1980
Less than 30	\$0.05	\$0.04
30 but less than 35	0.07	0.04
35 but less than 40	0.10	0.08
40 but less than 45	0.15	0.12
45 but less than 50	0.35	0.20
50 but less than 55	0.65	0.44
55 but less than 60	0.90	0.64
60 but less than 65	1.70	1.36
65 but less than 70	3.00	2.00

When the Employee attains a birthday which places the Employee in a higher age bracket, the monthly contribution will change, as set forth above, on the first day of the calendar month following the month in which such birthday occurs. If the amount of the Employee's Optional Group Life Insurance is changed because of a change in annual base salary, the monthly contribution will automatically change on the date such change in the amount of insurance becomes effective.

#### SECTION E.

##### AMOUNT OF OPTIONAL GROUP LIFE INSURANCE

The amount of the Employee's Optional Group Life Insurance until the end of the month in which the Employee attains age 65 shall be the amount designated on the Employee's enrollment election form filed with the records maintained by the Employer, determined in accordance with, and subject to, the provisions of Section C of this Part XIII.

If the Employee is insured for an amount of insurance determined by the Employee's annual base salary, any increase in the amount of insurance because of an increase in annual base salary shall become effective on the date of such salary increase (on the February 1st following the date of such salary increase, in the case of an Employee compensated wholly or partially on a commission basis), and any decrease in the amount of insurance because of a reduction in annual base salary shall become effective on the first day of the calendar month next following the date of such salary reduction (on the February 1st following the date of such salary reduction, in the case of an Employee compensated wholly or partially on a commission basis), provided, in any case, the Employee is actively at work on the date of such salary increase or, in the case of salary reduction, on such first day (in either case, on such February 1st in the case of an Employee compensated wholly or partially on a commission basis). If the Employee is not actively at work on the date an increase or decrease in the amount of insurance would otherwise become effective, such increase or decrease shall become effective on the date the Employee returns to active work.

The amount of insurance in force on account of the Employee as of the first day of the calendar month following the month in which the Employee attains age 65 shall be the amount for which the Employee was insured on the date the Employee attained age 65; such amount shall be reduced on the first day of the calendar month following the month in which the Employee attains age 66 and on each anniversary of such date by 20% of the amount of Optional Group Life Insurance in force on the Employee's 65th birthday. No insurance is provided after the end of the month in which the Employee attains age 70.

For an Employee with unbroken length of service on or after January 1, 1979 whose monthly base salary, annual earnings base, or salaried position classification changes

after the Employee's 65th birthday, and as a result the Employee is entitled to an increased or decreased amount of Optional Group Life Insurance, for the purposes of the provisions of the preceding paragraph, the amount of the Employee's Optional Group Life Insurance shall be determined as though such increased or decreased amount of Optional Group Life Insurance was the amount for which the Employee was insured on the Employee's 65th birthday.

#### SECTION F. BENEFICIARIES

The Beneficiary is the person or persons designated by the Employee, on a form approved by the Insurance Company and filed with the records maintained by the Employer in connection with the insurance under Group Policy No. 23600-G, to receive upon the Employee's death the amount of Optional Group Life Insurance then payable. Otherwise, the Optional Group Life Insurance is subject to the same provisions with respect to beneficiaries as are summarized under "Section B. Beneficiaries" in Part VI hereof.

#### SECTION G.

##### CESSATION OF OPTIONAL GROUP LIFE INSURANCE

The Optional Group Life Insurance shall automatically cease on whichever of the following dates is earliest:

(a) The date of termination of the Employee's employment because of quit or discharge, otherwise on the last day of the calendar month in which termination of employment occurs. "Termination of employment", as used herein, means cessation of active work as an Employee as defined in Part I hereof, except that

- (1) in the case of absence of the Employee from active work because of disability, layoff, or approved leave of absence, Optional Group Life Insurance may be continued by the payment of required contributions, monthly in advance, as long as the Employee's

Basic Group Life Insurance under Group Policy No. 14000-G remains in force, or

- (2) in certain other circumstances specified in Group Policy No. 23600-G, Optional Group Life Insurance may be continued by the payment of required contributions, monthly in advance.
- (b) The date the Employee ceases to be insured for Basic Group Life Insurance under Group Policy No. 14000-G.
- (c) The date of discontinuance of Group Policy No. 14000-G or the date of discontinuance of Group Policy No. 23600-G, whichever first occurs.
- (d) If any required contribution to the cost of the Employee's Optional Group Life Insurance under Group Policy No. 23600-G is not made when due, the last day of the calendar month preceding the calendar month for which such contribution was due.

#### SECTION H. PRIVILEGE OF OBTAINING AN INDIVIDUAL POLICY OF LIFE INSURANCE

1. Upon written application made to the Insurance Company within 31 days after

- (i) the date of cessation of the Employee's Optional Group Life Insurance due to the cessation of Basic Group Life Insurance under Group Policy No. 14000-G, except in the event that such cessation of Basic Group Life Insurance is due to the discontinuance of such Group Policy, or
- (ii) the date of the discontinuance of Group Policy No. 23600-G, provided such date is 5 years or more after the effective date of the Employee's Optional Group Life Insurance,

the Employee shall be entitled to have an individual policy of Life Insurance only, without Disability or Accidental

Means Death Benefits, issued by the Insurance Company, without evidence of insurability, subject to the following conditions and provisions:

- (A) Such individual policy shall be upon one of the forms then customarily issued by the Insurance Company, except Term Insurance, and
- (B) the premium for such individual policy shall be the premium applicable to the class of risk to which the Employee belongs and to the form and amount of the individual policy at the Employee's attained age at the date of issue of such individual policy, and
- (C) the amount of such individual policy shall be equal to (or at the option of the Employee less than) the amount of the Employee's Optional Group Life Insurance under Group Policy No. 23600-G on whichever of the dates specified in items (i) and (ii) above is applicable, except that if the Employee's Optional Group Life Insurance ceases under the circumstances described in item (ii) above, the amount of such individual policy shall not exceed the amount determined in accordance with the applicable provisions of Group Policy No. 23600-G.

2. Any individual policy of Life Insurance so issued shall become effective not earlier than the expiration of the 31-day period during which application for such individual policy may be made. If, however, the Employee dies during such 31-day period, the Insurance Company shall pay to the Employee's Beneficiary of record under Group Policy No. 23600-G, whether or not the Employee shall have made application for such individual policy, the maximum amount of Life Insurance for which an individual policy could have been issued under the provisions described in this Section H.

## SECTION I. ASSIGNMENT

The Employee may transfer by absolute and irrevocable assignment all the Employee's rights, title, interests and incidents of ownership, both present and future, under Group Policy No. 23600-G. No assignment shall be binding upon the Insurance Company unless it is in a form acceptable to the Insurance Company and until it has been accepted and filed at the Home Office of the Insurance Company. The Insurance Company and the Employer assume no obligation as to the validity or sufficiency of any assignment.

An assignment made pursuant to the above will not destroy the right to the death benefits of a beneficiary (or beneficiaries) last designated prior to such assignment and will leave unimpaired any Optional Mode of Settlement previously elected pursuant to the Section entitled "Optional Modes of Settlement" of Group Policy No. 23600-G relating to the death benefits payable to such beneficiary (or beneficiaries) in effect at the time of the assignment, if the assignee does not revoke the interest of such beneficiary (or beneficiaries), and if such beneficiary (or beneficiaries) survives the Employee.

## SECTION J. APPLICANT OWNER

Optional Group Life Insurance may be applied for, paid for, and owned by a person other than the Employee, provided such person is an adult who has the relationship to the Employee of a spouse, child, son-in-law, daughter-in-law, parent, brother, brother-in-law, sister, sister-in-law, grandchild, or grandparent.

If the Optional Group Life Insurance is owned by such a person (herein called Applicant Owner), all title and incidents of ownership in the Optional Group Life Insurance are vested in the Applicant Owner who alone may exercise every right and privilege with respect to such insurance which otherwise could have been exercised by

the Employee. In such event, all reference to Optional Group Life Insurance in this certificate shall be null, void, and of no effect, and nothing in this certificate shall pertain to such insurance.

If the Optional Group Life Insurance owned by an Applicant Owner ceases because of an event which causes the Applicant Owner to no longer qualify as an Applicant Owner, the Employee shall be automatically excluded from eligibility for Optional Group Life Insurance under Group Policy No. 23600-G on the date of cessation of such insurance.

. . . . .

The provisions of Parts I through XII and Part XIV of this certificate do not apply to Optional Group Life Insurance, except as specifically stated in this Part XIII.

#### PART XIV. APPLICABLE TO DEPENDENT GROUP LIFE INSURANCE

##### SECTION A. INSURING CLAUSE

If a Dependent, as defined in Section C of this Part XIV, of the Employee dies while the Employee is insured for Dependent Group Life Insurance under Group Policy No. 23950-G on account of such Dependent, the amount of such insurance in force on account of the Dependent at the date of the Dependent's death shall be paid to the Employee.

If a Dependent dies subsequent to the death of the Employee and while Dependent Group Life Insurance is in force, the amount of such insurance in force on account of the Dependent shall be paid to the Employee's estate or, at the option of the Insurance Company, to any one or more of the following surviving relatives of the Employee: wife, husband, mother, father, child or children; and payment to any one or more of such surviving relatives shall completely discharge the Insurance Company's liability with respect to the amount so paid.

#### SECTION B. ELIGIBILITY

An Employee, as defined in Part I hereof, is eligible for Dependent Group Life Insurance on the first day of the calendar month immediately following the date of completion of 6 months of service as determined by the Employer, provided that the Employee is insured for Optional Group Life Insurance under Group Policy No. 23600-G and has a Dependent, as defined in Section C of this Part XIV. Such first day is the Employee's eligibility date. If the Employee is not insured for such Optional Group Life Insurance or does not have such a Dependent, the Employee's eligibility date for Dependent Group Life Insurance will be the first day of the calendar month following the date both of these conditions are first met.

#### SECTION C. DEFINITION OF DEPENDENT

"Dependent" means (a) the Employee's spouse, and (b) any unmarried child over 14 days of age (i) of the Employee by birth, legal adoption, or legal guardianship, while such child legally resides with and is dependent upon the Employee, (ii) of the Employee's spouse while such child is in the custody of and dependent upon the Employee's spouse and is residing in and a member of the Employee's household, (iii) as defined in (i) and (ii) who does not reside with the Employee but is the Employee's legal responsibility for the provision of health care, and (iv) who resides with and is related by blood or marriage to the Employee, for whom the Employee provides principal support as defined by the Internal Revenue Code of the United States, and who was reported as dependent on the Employee's most recent income tax return or who qualifies in the current year for dependency tax status. A child as defined in (i), (ii), (iii), or (iv) is included until the end of the calendar year in which the child attains age 25, or regardless of age if totally and permanently disabled as defined hereinafter, provided that any such child after the end of the calendar year in which the child at-

tains age 19 must be dependent upon the Employee within the meaning of the Internal Revenue Code of the United States and must legally reside with, and be a member of the household of, the Employee. "Totally and permanently disabled" means having any medically determinable physical or mental condition prevents the child from engaging in substantial gainful activity and which can be expected to result in death or to be of long-continued or indefinite duration. The Employee shall submit periodically to the Insurance Company such evidence as it requires that such child is totally and permanently disabled, and determination of initial and continuing eligibility by the Insurance Company shall be conclusive.

No person may be considered a Dependent of more than one Employee.

#### SECTION D.

##### AMOUNT OF DEPENDENT GROUP LIFE INSURANCE

The amount of Dependent Group Life Insurance applicable to each Dependent prior to January 1, 1980 shall be the amount corresponding to the Schedule designated on the Employee's enrollment election form filed with the records maintained by the Employer, determined in accordance with the following Schedule I, II, III, IV, or V, and subject to the provisions of Section E of this Part XIV:

Schedule	Amounts of Insurance *	
	Spouse	Each Child
I	\$ 5,000	\$1,000
II	10,000	2,000
III	15,000	3,000
IV	20,000	4,000
V	25,000	5,000

\* The Amounts of Insurance shall be double the amounts shown above in the case of any Employee who submits a special election form prior to January 1, 1980.

The amount of Dependent Group Life Insurance applicable to each Dependent on and after January 1, 1980 shall be the amount corresponding to the Schedule designated on the Employee's enrollment election form filed with the records maintained by the Employer, determined in accordance with the following Schedule I, II, III, IV, or V, and subject to the provisions of Section E of this Part XIV:

Schedule	Amounts of Insurance	
	Spouse	Each Child
I	\$10,000	\$2,000
II	20,000	4,000
III	30,000	6,000
IV	40,000	8,000
V	50,000	10,000

#### SECTION E. ENROLLMENT AND EFFECTIVE DATE

An Employee may elect to enroll for Dependent Group Life Insurance by completing an enrollment election form approved by the Insurance Company.

Prior to January 1, 1980, the Employee may enroll for the amounts of insurance set forth in the first paragraph of Section D of this Part XIV.

Effective January 1, 1980, the Employee may enroll for the amounts of insurance corresponding to one of the Schedules set forth in the second paragraph of Section D of this Part XIV.

If the Employee enrolls on or before the Employee's eligibility date, the insurance becomes effective, with respect to those persons who are then Dependents of the Employee, on the eligibility date, provided the Employee is then actively at work and insured for Optional Group Life Insurance. If the Employee enrolls during the 31-day period following the Employee's eligibility date, the insurance becomes effective, with respect to those persons who are then Dependents of the Employee, on the first day of the calendar month following the date of the Employee's

enrollment, provided the Employee is then actively at work and insured for Optional Group Life Insurance.

If the Employee is not actively at work on the date the insurance would otherwise become effective with respect to those persons who are then Dependents of the Employee, the insurance will become effective on the next following day on which the Employee is actively at work and insured for Optional Group Life Insurance, provided that date is not more than 24 months later or, if such date is more than 24 months later, the Employee has not then broken recognized length of service as defined by the Employer.

The following four paragraphs are applicable to an Employee enrolled for the amounts of insurance set forth in the first paragraph of Section D of this Part XIV prior to January 1, 1980.

If the Employee does not enroll on or prior to the 31st day following the Employee's eligibility date, or if the Employee becomes insured under Group Policy No. 23950-G on account of any Dependent and prior to January 1, 1980 decides to elect higher amounts of insurance corresponding to Schedule II, III, IV, or V set forth in the first paragraph of Section D of this Part XIV, the Employee may become insured initially on account of any Dependent, or for such higher amounts of insurance, only by furnishing evidence satisfactory to the Insurance Company of the good health of such Dependent. Such evidence must be furnished to the Insurance Company by the Employee, at the Employee's own expense, on a form and in a manner approved by the Insurance Company.

If the required evidence with respect to any Dependent is accepted as satisfactory by the Insurance Company, the Employee will become insured initially, or for such higher amounts of insurance, on account of each Dependent whose evidence of good health is accepted as satisfactory, on the first day of the calendar month following the date such evidence is accepted as satisfactory, provided the

Employee is then actively at work, otherwise on the next following day on which the Employee is actively at work, and provided, further, that the Employee is then insured for Optional Group Life Insurance. If the required evidence with respect to any Dependent is not accepted as satisfactory by the Insurance Company, no Dependent Group Life Insurance shall be provided under Group Policy No. 23950-G with respect to such Dependent.

Notwithstanding the provisions of the two preceding paragraphs, the requirement to furnish evidence of the good health of any Dependent shall not apply to any Employee who elects to double the amount of Dependent Group Life Insurance in force on account of any Dependent by submitting a special election form to the Employer prior to January 1, 1980.

If the Employee becomes insured under Group Policy No. 23950-G on account of any Dependent and prior to January 1, 1980 decides to elect lower amounts of insurance corresponding to Schedule I, II, III, or IV set forth in the first paragraph of Section D of this Part XIV, the Employee will become insured for such lower amounts of insurance on the first day of the calendar month following the month for which the required monthly contribution was paid for the higher amounts, whether or not the Employee is then actively at work.

The following three paragraphs are applicable to an Employee enrolled for the amounts of insurance set forth in the second paragraph of Section D of this Part XIV on and after January 1, 1980.

If the Employee does not enroll on or prior to the 31st day following the Employee's eligibility date, or if the Employee becomes insured under Group Policy No. 23950-G on account of any Dependent and later decides to elect higher amounts of insurance corresponding to Schedule II, III, IV, or V set forth in the second paragraph of Section D of this Part XIV, the Employee may become insured initially on account of any Dependent, or for

such higher amounts of insurance, only by furnishing evidence satisfactory to the Insurance Company of the good health of such Dependent. Such evidence must be furnished to the Insurance Company by the Employee, at the Employee's own expense, on a form and in a manner approved by the Insurance Company.

If the required evidence with respect to any Dependent is accepted as satisfactory by the Insurance Company, the Employee will become insured initially, or for such higher amounts of insurance, on account of each Dependent whose evidence of good health is accepted as satisfactory, on the first day of the calendar month following the date such evidence is accepted as satisfactory, provided the Employee is then actively at work, otherwise on the next following day on which the Employee is actively at work, and provided, further, that the Employee is then insured for Optional Group Life Insurance. If the required evidence with respect to any Dependent is not accepted as satisfactory by the Insurance Company, no Dependent Group Life Insurance shall be provided under Group Policy No. 23950-G with respect to such Dependent.

If the Employee becomes insured under Group Policy No. 23950-G on account of any Dependent and later decides to elect lower amounts of insurance corresponding to Schedule I, II, III, or IV set forth in the second paragraph of Section D of this Part XIV, the Employee will become insured for such lower amounts of insurance on the first day of the calendar month following the month for which the required monthly contribution was paid for the higher amounts, whether or not the Employee is then actively at work.

Dependent Group Life Insurance with respect to any person who becomes a Dependent as defined in Section C of this Part XIV while the Employee is insured for Dependent Group Life Insurance shall become effective on the date such person becomes such a Dependent.

## SECTION F. CONTRIBUTIONS

Employee contribution to the cost of Dependent Group Life Insurance are required for such insurance to be in force on account of any Dependent. The required monthly contribution for Dependent Group Life Insurance, regardless of the number of Dependents on whose account the Employee is insured, is as set forth in the following schedule, which is subject to change.

Employee's Age	Monthly Contribution According to Schedule of Amounts of Insurance Set Forth in the First Paragraph of Section D of this Part XIV *				
	I	II	III	IV	V
Less than 30	\$0.25	\$0.50	\$0.75	\$1.00	\$1.25
30 but less than 35	0.35	0.70	1.05	1.40	1.75
35 but less than 40	0.45	0.90	1.35	1.80	2.25
40 but less than 45	0.70	1.40	2.10	2.80	3.50
45 but less than 50	1.25	2.50	3.75	5.00	6.25
50 but less than 55	2.20	4.40	6.60	8.80	11.00
55 but less than 60	3.20	6.40	9.60	12.80	16.00
60 but less than 65	4.75	9.50	14.25	19.00	23.75
65 but less than 70	7.05	14.10	21.15	28.20	35.25

\* The monthly contribution shall be double the amounts shown in the case of any Employee who submits a special election form prior to January 1, 1980.

Employee's Age	Monthly Contribution According to Schedule of Amounts of Insurance Set Forth in the Second Paragraph of Section D of this Part XIV				
	I	II	III	IV	V
Less than 30	\$0.50	\$1.00	\$1.50	\$2.00	\$2.50
30 but less than 35	0.70	1.40	2.10	2.80	3.50
35 but less than 40	0.90	1.80	2.70	3.60	4.50
40 but less than 45	1.40	2.80	4.20	5.60	7.00
45 but less than 50	2.50	5.00	7.50	10.00	12.50
50 but less than 55	4.40	8.80	13.20	17.60	22.00
55 but less than 60	6.40	12.80	19.20	25.60	32.00
60 but less than 65	9.50	19.00	28.50	38.00	47.50
65 but less than 70	14.10	28.20	42.30	56.40	70.50

When the Employee attains a birthday which places the Employee in a higher age bracket, the monthly contribution will change, as set forth above, on the first day of the calendar month following the month in which such birthday occurs.

#### SECTION G.

##### CESSATION OF DEPENDENT GROUP LIFE INSURANCE

1. The Dependent Group Life Insurance shall automatically cease on whichever of the following dates is earliest:

(a) The date of termination of the Employee's employment because of quit or discharge, otherwise on the last day of the calendar month in which termination of employment occurs. "Termination of employment", as used herein, means cessation of active work as an Employee, as defined in Part I hereof, except that in the case of absence of the Employee from active work because of lay-off, approved leave of absence, or retirement, Dependent Group Life Insurance may be continued by the payment of required contributions, monthly in advance, as long as the Employee is insured for Optional Group Life Insurance under Group Policy No. 23600-G and has a Dependent as defined in Section C of this Part XIV.

(b) The date the Employee ceases to have any Dependent as defined in Section C of this Part XIV.

(c) The date the Employee ceases to be insured for Optional Group Life Insurance under Group Policy No. 23600-G.

(d) The date of discontinuance of Group Policy No. 23600-G or the date of discontinuance of Group Policy No. 23950-G, whichever first occurs.

(e) If any required contribution to the cost of the Employee's Dependent Group Life Insurance under Group Policy No. 23950-G is not made when due, the last day of the calendar month preceding the calendar month for which such contribution was due.

2. The Dependent Group Life Insurance on account of any Dependent shall automatically cease on the day immediately preceding the date such person ceases to be a Dependent as defined in Section C of this Part XIV.

#### SECTION H. PRIVILEGE OF OBTAINING AN INDIVIDUAL POLICY OF LIFE INSURANCE

1. Upon written application made by a person to the Insurance Company within 31 days after the date of cessation of the Dependent Group Life Insurance on account of such person because of

- (i) termination of the Employee's employment for reasons other than retirement, or
- (ii) such person's ceasing to be a Dependent as defined in Section C of this Part XIV,

such person shall be entitled to have an individual policy of Life Insurance only, without Disability or Accidental Means Death Benefits, issued by the Insurance Company, without evidence of insurability, subject to the following conditions and provisions:

- (A) Such individual policy shall be upon one of the forms then customarily issued by the Insurance Company, except Term Insurance, and
- (B) the premium for such individual policy shall be the premium applicable to the class of risk to which such person belongs and to the form and amount of the individual policy at such person's attained age at the date of issue of such individual policy, and
- (C) the amount of such individual policy shall be equal to (or at the option of such person less than) the amount of Dependent Group Life Insurance in force on account of such person on the date of cessation of such insurance.

If such person is a minor whose age precludes direct application for an individual policy, then application for such individual policy on the life of such minor may be made by the Employee, if living, otherwise by the person who, in the judgment of the Insurance Company, is responsible for the support of such minor. The issuance of an individual policy on the life of such minor shall be subject to the provisions and limitations of any applicable law relating to life insurance on the lives of minors.

2. Any individual policy of Life Insurance so issued shall become effective not earlier than the expiration of the 31-day period during which application for such individual policy may be made. If, however, the person who is entitled to the privilege of obtaining an individual policy of Life Insurance dies during such 31-day period, the Insurance Company shall pay to the Employee, whether or not application for such individual policy shall have been made, the maximum amount of Life Insurance for which an individual policy could have been issued under this Section H, provided that, if the Employee is not living at the date of death of such person, such amount shall be paid to such person's estate or, at the option of the Insurance Company, to any one or more of the following surviving relatives of such person: mother, father, child or children, brothers or sisters; and payment to any one or more of such surviving relatives shall completely discharge the Insurance Company's liability with respect to the amount so paid.

\* \* \* \* \*

The provisions of Parts I through XIII of this certificate do not apply to Dependent Group Life Insurance, except as specifically stated in this Part XIV.

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

No. 82-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,

*Plaintiff,*

—vs—

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

FIRST AMENDED COMPLAINT

NOW COMES the plaintiff, ARTHUR TAYLOR, by and through his attorneys, JAMES A. BRESCOLL, P.C., and for his First Amended Complaint against defendants General Motors Corporation and Metropolitan Life Insurance Company, alleges as follows:

*Count I—Public Policy Torts*

1. That the plaintiff is a resident of the City of Flint, County of Genessee, State of Michigan.
2. That General Motors Corporation is a Delaware corporation with its principal place of business in Michigan and Metropolitan Life Insurance Company is a New York corporation licensed to do business in Michigan.
3. That the amount in controversy exceeds Ten Thousand Dollars (\$10,000.00) exclusive of interest and costs or is otherwise within the jurisdiction of the court.

4. That on or about July of 1955, plaintiff accepted General Motors' offer of employment and agreed to furnish his services as an engineer in General Motors Corporation.

5. That in August of 1963, plaintiff was involved in an automobile accident which occurred in the course of plaintiff's employment with General Motors Corporation.

6. That as a direct and proximate result of said accident, plaintiff suffered injuries to his back, neck, head and legs.

7. That despite the treatment and medical attention plaintiff received immediately after the accident, plaintiff has been hospitalized on numerous occasions since the date of the accident, has been treated and examined by numerous doctors and specialists, and has made every reasonable effort to correct his back and neck problem.

8. That plaintiff has been diagnosed as having degenerative osteoarthritis of the cervical and lumbosacral spine, a permanent medical impairment which limits plaintiff's walking, standing, climbing, etc.

9. That plaintiff's doctors, supported by numerous consulting specialists, have pronounced plaintiff totally disabled from returning to normal and customary work duties with General Motors Corporation.

10. That prior to plaintiff's condition becoming totally disabling, his doctors placed travel restrictions on plaintiff and also recommended that he move to a warm, dry climate for therapeutic trial to live for at least six months.

11. That each and every work restriction placed on plaintiff from a medical standpoint was met with a greater resistance and harassment from the departmental management at General Motors, i.e., after plaintiff's doctors recommended a transfer to a warm, dry climate, management at General Motors attempted to transfer plaintiff, to a cold, damp warehouse.

12. That in addition to plaintiff's severe physical limitations, the continuing harassment and stress of plaintiff by defendant's agents caused plaintiff to suffer a psychological breakdown.

13. That plaintiff's psychologist pronounced plaintiff to be totally disabled from returning to normal and customary work duties with General Motors Corporation.

14. That plaintiff has filed a worker's compensation claim with General Motors and submitted to medical examinations by General Motors' doctors.

15. That after brief and superficial examinations by General Motors' doctors, they concluded plaintiff's medical condition had improved to the level where plaintiff could again report to work, despite extensive medical and psychological documentation and evidence to the contrary.

16. That in the first two years that the plaintiff was employed with defendant he was promoted twice, but after the plaintiff's filing of worker's compensation claims and the utilization by plaintiff of defendant's "Open Door Policy", the defendant failed to promote plaintiff over the years in retaliation for his filing said worker's compensation claims, and finally terminated him from his position with General Motors Corporation on November 5, 1980, allegedly for failing to report back to work as ordered by General Motors Corporation.

17. That two of the actual reasons for plaintiff's discharge were that: (a) plaintiff's serious medical and psychological condition required medical restrictions to be placed on him, restrictions which General Motors objected to; and (b) plaintiff filed a worker's compensation claim for his total disability with General Motors and General Motors' firing of the plaintiff was in retaliation for filing said claim.

18. That General Motors' discharge of plaintiff because of medical and psychological restrictions placed on

him and in retaliation for filing a worker's compensation case or against the public policy of this state.

19. That because of the aforementioned alleged retaliation by General Motors, plaintiff has sustained loss of earnings and earning capacity, including fringe benefits and has suffered severe mental anguish all of which damages will continue into the future.

WHEREFORE, plaintiff demands judgment against the defendant General Motors Corporation for whatever amount above Ten Thousand Dollars (\$10,000.00) he is found to be entitled including compensatory, exemplary and punitive damages together with interest, costs and attorney fees.

*Count II—Breach of Insurance Contract*

For Count II of his First Amended Complaint, plaintiff alleges as follows:

20. That plaintiff hereby adopts and incorporates by reference, each and every allegation contained in Paragraphs 1-19 of Count I herein as Paragraph 20 of Count II.

21. That pursuant to plaintiff's employment agreement with General Motors Corporation, General Motors Corporation agreed to provide certain benefits and insurance coverage to plaintiff.

22. That the premium for said benefits and insurance policies were paid by General Motors Corporation for plaintiff's benefit.

23. That the following were provided through the Metropolitan Life Insurance Company to plaintiff:

(a) Basic Group Life Insurance and Extra Accident Insurance (Group Policy No. 14000-G);

(b) Survivor Income Benefit Insurance (Group Policy No. 22500-G);

(c) Sickness and Accident Insurance and Extended Disability Benefit Insurance (Group Policy No. 18501-G).

24. That said Sickness and Accident Insurance Policy, effective date 1977, provided that in the event of total disability and the inability to work, certain monthly benefits were to be paid.

25. That the 1980 General Motors personnel benefit summary stated that in the event of total disability, plaintiff was entitled to receive salary continuation and/or disability benefits of Two Thousand Four Hundred and Sixty-Two (\$2,462.00) Dollars per month for twenty-six (26) weeks and One Thousand Eight Hundred and Thirteen (\$1,813.00) Dollars per month for the next twenty-seven (27) weeks.

26. That on July 30, 1980, when said Sickness and Accident Insurance Policy was in full force and when plaintiff was totally disabled and dependent on said monthly benefits for his entire income, Metropolitan Life Insurance Company wrongfully and maliciously discontinued said insurance coverage in breach of the insurance contract.

27. That due notice of plaintiff's disability was given to the insurer, Metropolitan Life Insurance Company, and plaintiff has duly performed all the conditions of said policy on his part.

28. That the termination of disability payments has caused plaintiff great financial hardship and left plaintiff unable to adequately provide for or support himself and his two minor sons, for whom plaintiff is sole legal guardian.

29. That as a result of the improper discontinuance of said benefits, plaintiff has suffered great mental anguish due to the real and distinct possibility that plaintiff will lose custody of his two sons.

30. That this is a real possibility because plaintiff lacks the means to adequately support them and provide for their basic human and medical needs.

31. That plaintiff's back condition and psychological condition prevents him from gaining other meaningful employment.

WHEREFORE, plaintiff demands judgment against the defendant Metropolitan Life Insurance Company for whatever amount above Ten Thousand Dollars (\$10,000.00) he is found to be entitled including compensatory, exemplary and punitive damages together with interest, costs and attorney fees.

*Count III—Breach of Employment Contract*

For Count III of his First Amended Complaint, plaintiff alleges as follows:

32. That plaintiff hereby adopts and incorporates by reference, each and every allegation in Paragraphs 1-19 of Count I and 20-31 of Count II as Paragraph 32 of Count III.

33. That when plaintiff was hired by defendant General Motors Corporation, and subsequent thereto, defendant, through its authorized agents, represented to plaintiff that plaintiff had real job security in that he would not be discharged without just cause and established a company policy to that effect.

34. That additionally defendant represented to plaintiff through its "Open Door Policy" that when plaintiff has a problem with his work he would be provided a fair and open place to work, that an open channel of communications would exist between the plaintiff and all levels of management, that he would be free from any reprisals when he used the open door channels, that he would have active assistance from his supervisors and he would be safeguarded against improper decisions and actions by management.

35. That the plaintiff was a contractual employee of defendant pursuant to the aforesaid representations which constituted an offer for a unilateral contract which plaintiff relied upon and accepted by loyally and faithfully performing the requested services for defendant for twenty-five (25) years, and thus he could not be legally discharged by defendant contrary to the terms and conditions of said contract.

36. That the plaintiff was arbitrarily, unreasonably, ruthlessly and maliciously discharged by defendant without warning on November 5, 1980, in breach of said contract.

37. That as a result of the aforementioned wrongful discharge of the plaintiff by the defendant constituting a breach of contract, the plaintiff has been deprived of the wages and fringe benefits he would have been entitled to as defendant's employee and of future wages and benefits from defendant that he was reasonably relying upon to provide security for himself and his family, and has suffered extreme mental anguish which will continue for the rest of his life.

38. That the amount in controversy between the parties hereto exceeds Ten Thousand Dollars (\$10,000.00), exclusive of interest, costs and attorney fees.

WHEREFORE, plaintiff demands judgment against the defendant General Motors Corporation for whatever amount above Ten Thousand Dollars (\$10,000.00) he is found to be entitled, including compensatory, exemplary and punitive damages together with interest, costs and attorney fees.

By: /s/ James A. Brescoll, P.C.  
JAMES A. BRESCOLL (P 11181)  
Attorneys for Plaintiff  
48 North Walnut Street  
Mount Clemens, Michigan 48043  
Telephone: 469-0300

DATED: October 20, 1983

## PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing instrument was served upon the attorney of record of all parties to the above cause by mailing the same to them at their respective business addresses as disclosed by the pleadings of record herein with postage fully prepaid thereon on the 20th day of October, 1983.

/s/ Linda M. Wheaton

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

\_\_\_\_\_  
No. 81-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,

*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

\_\_\_\_\_  
DEMAND FOR JURY TRIAL

NOW COMES the plaintiff, ARTHUR TAYLOR, by and through his attorneys, JAMES A. BRESCOLL, P.C., and hereby demands trial by jury of the above-captioned cause.

JAMES A. BRESCOLL, P.C.

By: /s/ James A. Brescoll  
JAMES A. BRESCOLL (P 11181)  
Attorneys for Plaintiff  
48 North Walnut Street  
Mount Clemens, Michigan 48043  
Telephone: 469-0300

DATED: October 20, 1983

**PROOF OF SERVICE**

The undersigned certifies that a copy of the foregoing instrument was served upon the attorney of record of all parties to the above cause by mailing the same to them at their respective business addresses as disclosed by the pleadings of record herein with postage fully prepaid thereon on the 20th day of October, 1983.

/s/ Linda M. Wheaton

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION**

---

No. 81-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,

*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

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**ANSWER OF GENERAL MOTORS CORPORATION  
TO PLAINTIFF'S FIRST AMENDED COMPLAINT**

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**CERTIFICATE OF SERVICE**

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DAVID M. DAVIS (P24006)  
Attorney for Defendant  
General Motors Corporation  
3044 West Grand Boulevard  
Detroit, Michigan 48202  
Telephone: (313) 556-4196

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

---

No. 82-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,

*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

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ANSWER OF GENERAL MOTORS CORPORATION  
TO PLAINTIFF'S FIRST AMENDED COMPLAINT

NOW COMES Defendant, General Motors Corporation, by and through its attorney, David M. Davis, and in answer to the First Amended Complaint filed herein says as follows:

COUNT I

*PUBLIC POLICY TORTS*

1. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count I, Paragraph 1 of the Amended Complaint and leaves Plaintiff to his proofs.

2. This Defendant admits that it is a corporation existing under the laws of the State of Delaware and is licensed to do and is doing business in the State of Michigan. All other allegations of Count I, Paragraph 2 are denied.

3. The allegations of Count I, Paragraph 3 are hereby denied and Plaintiff is left to his proofs.

4. The allegations of Count I, Paragraph 4 are hereby denied. Defendant admits only that Plaintiff commenced employment at Fisher Body, Willow Run, on June 25, 1959. Thereafter he was transferred to Chevrolet Motor Division on October 10, 1961. Additionally, Plaintiff has had prior service with General Motors Corporation at Buick Motor Division from February, 1951 to September, 1951 and at A.C. Spark Plug from April, 1953 to August, 1958.

5. This Defendant does not have personal knowledge sufficient to form a belief as to the truth or falsity of allegations of Count I, Paragraph 5 and, therefore, leaves Plaintiff to his proofs.

6. The allegations of Count I, Paragraph 6 are hereby denied and Plaintiff is left to his proofs.

7. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count I, Paragraph 7 and therefore leaves Plaintiff to his proofs.

8. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count I, Paragraph 8 and therefore leaves Plaintiff to his proofs.

9. The allegations of Count I, Paragraph 9 of the Amended Complaint are hereby denied and Plaintiff is left to his proofs.

10. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count I, Paragraph 10 and therefore leaves Plaintiff to his proofs.

11. The allegations of Count I, Paragraph 11 are hereby denied and Plaintiff is left to his proofs.

12. The Allegations of Count I, Paragraph 12 are hereby denied and Plaintiff is left to his proofs.

13. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count I, Paragraph 13, and, therefore, leaves Plaintiff to his proofs.

14. This Defendant admits only that Plaintiff has filed a workers' compensation claim with the Department of Labor, State of Michigan. All other allegations of Count I, Paragraph 14 are denied and Plaintiff is left to his proofs.

15. The allegations of Count I, Paragraph 15 are hereby denied and Plaintiff is left to his proofs.

16. The allegations of Count I, Paragraph 16 of the Amended Complaint are hereby denied and Plaintiff is left to his proofs.

17. The allegations of Count I, Paragraph 17 are hereby denied and Plaintiff is left to his proofs.

18. The allegations of Count I, Paragraph 18 are hereby denied and Plaintiff is left to his proofs.

19. The allegations of Count I, Paragraph 19 are hereby denied and Plaintiff is left to his proofs.

WHEREFORE, Defendant General Motors Corporation prays that Plaintiff's Amended Complaint filed herein be dismissed and that Plaintiff take nothing by reason of such Amended Complaint and further that said Defendant be awarded its costs and reasonable attorneys fees.

## COUNT II

### *BREACH OF INSURANCE CONTRACT*

20. Defendant General Motors Corporation hereby adopts and incorporates by reference each and every response to Count I, Paragraphs 1-19, of Plaintiff's Amended Complaint as if such responses were set out in full herein.

21. The allegations of Count II, Paragraph 21 are hereby denied and Plaintiff is left to his proofs.

22. The allegations of Count II, Paragraph 22 are hereby denied and Plaintiff is left to his proofs.

23. This Defendant makes no response to this Paragraph but rather refers to the terms and conditions of the group policies identified in Count II, Paragraph 23 of the Amended Complaint.

24. This defendant refers specifically to the terms and conditions governing sickness and accident benefits. All allegations of Count II, Paragraph 24 are denied.

25. This Defendant refers specifically to the 1980 General Motors Personal Benefit Summary. All allegations of Count II, Paragraph 25 are hereby denied and Plaintiff is left to his proofs.

26. Defendant General Motors Corporation makes no response to Count II, Paragraph 26 because said paragraph is directed against Defendant Metropolitan Life Insurance Company.

27. Defendant General Motors Corporation makes no response to Count II, Paragraph 27 of the Amended Complaint because said paragraph is directed against Metropolitan Life Insurance Company.

28. This Defendant does not have knowledge sufficient to form a belief as to the truth or falsity of the allegations of Count II, Paragraph 28 and therefore leave Plaintiff to his proofs.

29. The allegations of Count II, Paragraph 29 of the Amended Complaint are denied and Plaintiff is left to his proofs.

30. The allegations of Count II, Paragraph 30 are hereby denied and Plaintiff is left to his proofs.

31. The allegations of Count II, Paragraph 31 are hereby denied and Plaintiff is left to his proofs.

WHEREOF, Defendant General Motors Corporation prays that Plaintiff's Amended Complaint be dismissed, that Plaintiff take nothing by his Amended Complaint, and that this Defendant be awarded its costs and attorneys' fees in defending this matter.

### COUNT III

#### *BREACH OF EMPLOYMENT CONTRACT*

32. Defendant General Motors Corporation hereby adopts and incorporates by reference each and every response to Count I, Paragraph 1-19 and Count II, Paragraphs 20-31 as if such responses were set out in full herein.

33. The allegations of Count III, Paragraph 33 are hereby denied and Plaintiff is left to his proofs.

34. The allegations of Count III, Paragraph 34 are hereby denied and Plaintiff is left to his proofs. Defendant's "Open Door Policy" speaks for itself.

35. Defendant admits that on or about March 31, 1960 Plaintiff and Defendant entered into an Employment Agreement, a copy of which is attached hereto as Exhibit A, and has executed numerous Compensation Statements including those executed in 1977, 1978 and 1979, attached hereto as Exhibits, B, C and D, respectively. All other allegations of Count III, Paragraph 35 are hereby denied and Plaintiff is left to his proofs.

36. The allegations of Count III, Paragraph 36 are hereby denied and Plaintiff is left to his proofs.

37. The allegations of Count III, Paragraph 37 are hereby denied and Plaintiff is left to his proofs.

38. The allegations of Count III, Paragraph 38 are hereby denied and Plaintiff is left to this proofs.

WHEREFORE, Defendant General Motors Corporation prays that Plaintiff's Amended Complaint be dismissed, that Plaintiff take nothing by his Amended Complaint and that this Defendant be awarded its costs and attorneys' fees in defending this matter.

### AFFIRMATIVE DEFENSES

1. Plaintiff has failed to state a claim.
2. Plaintiff has failed to state a claim upon which relief can be granted.
3. Plaintiff's action cannot be maintained in this Court because it is within the exclusive jurisdiction of the Bureau of Worker's Disability Compensation, Department of Labor, State of Michigan.
4. Plaintiff may not maintain this action against this Defendant because such action is barred by the applicable statute of limitations.
5. Plaintiff is barred from maintaining his contractual action because of the applicable statute of frauds.
6. Plaintiff is estopped from maintaining his contractual action because of the terms and conditions of his Employment Agreement and Compensation Statements.
7. Plaintiff cannot maintain this action because he has failed to exhaust remedies available to him that would have provided him with a review of his complaints alleged herein.

WHEREFORE, Defendant General Motors Corporation prays that Plaintiff's Amended Complaint be dismissed, that Plaintiff take nothing by his Amended Com-

plaint and that this Defendant be awarded its costs and attorneys' fees in defending this matter.

Respectfully submitted,

By David M. Davis  
DAVID M. DAVIS (P24006)  
Attorney for Defendant  
General Motors Corporation  
3044 West Grand Boulevard  
Detroit, Michigan 48202  
Telephone: (313) 556-4196

# EXHIBIT A

## EMPLOYMENT AGREEMENT

THIS AGREEMENT, effective the 1 day of March, 1960, between Chervolet—C. O. Division, GENERAL MOTORS CORPORATION, hereinafter called the "Employer" and Arthur L. Taylor, hereinafter called the "Employee,"

### WITNESSETH:

1. The Employee agrees to devote his time and service in the employ of the Employer in such capacity as the Employer may direct.
2. The Employee acknowledges that his employment under this agreement is from month to month only on a calendar month basis.
3. In consideration of the services to be performed by the Employee for the Employer, in any and every capacity, the Employer agrees to pay the Employee, in one or more installments, as long as the employment under this agreement continues, compensation at the monthly rate set forth on the "Compensation Statement", signed by the Employee, accepted by the Employer, and on file in the Payroll Records of the Employer, from the date specified in such "Compensation Statement" and for the effective period thereof. Any "Compensation Statement" so signed and accepted, is hereby incorporated by reference as a part hereof, for the effective period of such "Compensation Statement".
4. A "Compensation Statement" in effect from the 1 day of March 1960 is being signed, accepted and filed simultaneously with the execution of this agreement, but such "Compensation Statement" may be cancelled and replaced by a new "Compensation Statement", signed by the Employee and accepted by the Employer, to reflect any changes in the monthly rate of the Employee's compensa-

tion, and any replacing "Compensation Statement" may be similarly cancelled and replaced for a similar purpose, without in any way affecting or modifying the provisions of this agreement, except to change and make effective the monthly rate of compensation set forth in the effective "Compensation Statement" from the effective date specified therein.

5. In consideration of the compensation paid the Employee by the Employer in connection with his employment by the Employer and the opportunity which such employment affords the Employee to become acquainted with the Employer's business, including the activities of the Employer in connection with engineering, research or development work, the Employee agrees that any inventions or improvements which he may conceive, make, invent or suggest during his employment by the Employer under this agreement relating to any matter or thing, including processes and methods of manufacture, which may be connected in any way with the Employee's work or related in any way to the Employer's business, existing or anticipated, at any time during his employment, shall be the absolute property of the Employer, and shall be promptly disclosed to the Employer by the Employee; and for the consideration above mentioned the Employee agrees that he will at the request of the Employer, at any time during his employment or thereafter assign to the Employer the said inventions and improvements and any patent applications filed or patents granted thereon and will execute any patent papers covering such inventions or improvements as well as any papers that the Employer may consider necessary or helpful in the prosecution of patent applications thereon or in the conduct of any interference, litigation or any other controversy in connection therewith, all expense incident to the filing of such applications, the prosecution thereof, and the conduct of any such interference, litigation, or other controversy to be borne by the Employer. The Employee further agrees not to reveal to any person, unless authorized by the Em-

ployer or its duly authorized officials, any information concerning the inventions, improvements, or other confidential matters of the Employer.

6. The Employer and the Employee acknowledge that there are no other arrangements, agreements, or understandings, verbal or in writing, regarding same and that any modification or amendment hereof, other than a cancellation and replacement hereof by another written form of agreement, must be endorsed hereon in writing and initialed by both the Employee and the Employer.

Dated: 3-31, 1960

/s/ Arthur L. Taylor  
(Employee)  
Chevrolet—Central Office  
GENERAL MOTORS  
CORPORATION  
(Employer)

Dated: 4-1, 1960

/s/ H. K. Tucker

## EXHIBIT B

## COMPENSATION STATEMENT

Name of Employee

ARTHUR L. TAYLOR                      376-28-8656                      A200

TO: 13001 CHEVROLET MOTOR DIVISION  
(EMPLOYER)

Commencing SEPTEMBER 01, 1977, my compensation rate has been and is \$2,083.30 per month.

I understand that I am classified as an exempt employee under the provisions of the Fair Labor Standards Act and that my "Employment Agreement," of which this statement is a part, contemplates that the rate provided for above shall compensate me for all hours worked, including overtime, during each monthly period, provided, however, that a cost-of-living allowance, a night shift premium, on extended workweek salary premium or on overtime premium for scheduled overtime hours may be paid me in accordance with the policy or practice in effect, if approved by the executive directly in charge of the unit in which I am employed. The receipt and acceptance by me of a statement of my earnings for any period or the cashing of my pay check, without protest in writing to your representative having charge of your Payroll Records, shall constitute an acknowledgment by me that I have been paid in full for overtime and/or night shift hours for the period with respect to which said statement or pay check constitutes payment for overtime and/or night shift hours in accordance with the regular practice of my Employing Unit.

When signed and accepted, this statement, for the effective period hereof, becomes a part of my basic Employment Agreement," in accordance with the terms thereof, as heretofore executed and presently in effect.

This statement replaces any and all "Compensation Statements" heretofore executed by me and accepted by you and shall continue in effect until the basic "Employment Agreement" hereinbefore mentioned or my employment thereunder is terminated, or until replaced by a "Compensation Statement" hereafter signed by me and accepted by you, whichever first occurs.

In consideration of my continued employment, as evidenced by the "Employment Agreement" herein referred to, I acknowledge that I have received all compensation due me as an employee of yours for all services rendered during all periods ending prior to and on the last day of the month immediately preceding the date of signing of this statement.

There are no other arrangements, agreements, understandings, or statements, verbal or in writing, regarding the foregoing, except as hereinabove stated and no modification or amendment hereof, other than a cancellation and replacement hereof by another written form of "Compensation Statement," shall be effective, unless endorsed hereon in writing, and initialed by me and my Employer.

Dated: 9-19, 1977

ACCEPTED:

/s/ Arthur L. Taylor  
(Employee)

Dated: Sep. 28, 1977

By /s/ F. W. Kitzler  
(For The Employer)

## EXHIBIT C

## COMPENSATION STATEMENT

Name of Employee

ARTHUR L. TAYLOR                      376-28-8656                      A200

TO: 13001 CHEVROLET MOTOR DIVISION  
(EMPLOYER)

Commencing OCTOBER 01, 1978, my compensation rate has been and is \$2,146.84 per month.

I understand that I am classified as an exempt employee under the provisions of the Fair Labor Standards Act and that my "Employment Agreement," of which this statement is a part, contemplates that the rate provided for above shall compensate me for all hours worked, including overtime, during each monthly period, provided, however, that a cost-of-living allowance, a night shift premium, on extended workweek salary premium or on overtime premium for scheduled overtime hours may be paid me in accordance with the policy or practice in effect, if approved by the executive directly in charge of the unit in which I am employed. The receipt and acceptance by me of a statement of my earnings for any period or the cashing of my pay check, without protest in writing to your representative having charge of your Payroll Records, shall constitute an acknowledgment by me that I have been paid in full for overtime and/or night shift hours for the period with respect to which said statement or pay check constitutes payment for overtime and/or night shift hours in accordance with the regular practice of my Employing Unit.

When signed and accepted, this statement for the effective period hereof, becomes a part of my basic "Employment Agreement," in accordance with the items thereof, as heretofore executed and presently in effect.

This statement replaces any and all "Compensation Statements" heretofore executed by me and accepted by you and shall continue in effect until the basic "Employment Agreement" hereinbefore mentioned or my employment thereunder is terminated, or until replaced by a "Compensation Statement" hereafter signed by me and accepted by you, whichever first occurs.

In consideration of my continued employment, as evidenced by the "Employment Agreement" herein referred to, I acknowledge that I have received all compensation due me as an employee of yours for all services rendered during all periods ending prior to and on the last day of the month immediately preceding the date of signing of this statement.

There are no other arrangements, agreements, understandings, or statements, verbal or in writing, regarding the foregoing, except as hereinabove stated and no modification or amendment hereof, other than a cancellation and replacement hereof by another written form of "Compensation Statement," shall be effective, unless endorsed hereon in writing, and initialed by me and my Employer.

Dated: 10/14/1978

ACCEPTED: 10/14/79 /s/ Arthur L. Taylor  
(Employee)

Dated: 10-25, 1978 By /s/ G. Collins  
(For The Employer)

## EXHIBIT D

## COMPENSATION STATEMENT

Name of Employee

ARTHUR L. TAYLOR                      376-28-8656      A200

TO: 13001 CHEVROLET MOTOR DIVISION  
(EMPLOYER)

Commencing OCTOBER 01, 1979, my compensation rate has been and is \$2,417.24 per month.

I understand that I am classified as an exempt employee under the provisions of the Fair Labor Standards Act and that my "Employment Agreement," of which this statement is a part, contemplates that the rate provided for above shall compensate me for all hours worked, including overtime, during each monthly period, provided, however, that a cost-of-living allowance, a night shift premium, on extended workweek salary premium or on overtime premium for scheduled overtime hours may be paid me in accordance with the policy or practice in effect, if approved by the executive directly in charge of the unit in which I am employed. The receipt and acceptance by me of a statement of my earnings for any period or the cashing of my pay check, without protest in writing to your representative having charge of your Payroll Records, shall constitute an acknowledgment by me that I have been paid in full for overtime and/or night shift hours for the period with respect to which said statement or pay check constitutes payment for overtime and/or night shift hours in accordance with the regular practice of my Employing Unit.

When signed and accepted, this statement, for the effective period hereof, becomes a part of my basic "Employment Agreement," in accordance with the terms thereof, as heretofore executed and presently in effect.

This statement replaces any and all "Compensation Statements" heretofore executed by me and accepted by you and shall continue in effect until the basic "Employment Agreement" hereinbefore mentioned or my employment thereunder is terminated, or until replaced by a "Compensation Statement" hereafter signed by me and accepted by you, whichever first occurs.

In consideration of my continued employment, as evidenced by the "Employment Agreement" herein referred to, I acknowledge that I have received all compensation due me as an employee of yours for all services rendered during all periods ending prior to and on the last day of the month immediately preceding the date of signing of this statement.

There are no other arrangements, agreements, understandings, or statements, verbal or in writing, regarding the foregoing, except as hereinabove stated and no modification or amendment hereof, other than a cancellation and replacement hereof by another written form of "Compensation Statement," shall be effective, unless endorsed hereon in writing, and initialed by me and my Employer.

Dated: 10-17-1979

ACCEPTED:

/s/ Arthur L. Taylor  
(Employee)

Dated: Oct. 26, 1979

By /s/ V. J. Kunnoth  
(For The Employer)

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

No. 81-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,

*Plaintiff,*

v.

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

CERTIFICATE OF SERVICE

STATE OF MICHIGAN)

) ss.

COUNTY OF WAYNE )

I Barbara K. Hampson, hereby certify that on the 20th day of October, 1983, I served a copy of the Answer of General Motors Corporation to Plaintiff's First Amended Complaint in the above-captioned matter, by depositing same in a U.S. mail receptacle with postage fully prepaid thereon, upon:

James A. Brescoll, Esq.  
48 North Walnut Street  
Mt. Clemens, Mich. 48043

Gilbert Y. Rubenstein, Esq.  
1026 Mott Foundation Bldg.  
Flint, Michigan 48502

/s/ Barbara K. Hampson  
BARBARA K. HAMPSON

Subscribed and sworn to before  
me this 20th day of October, 1983.

/s/ Marilyn G. deRaad

MARILYN G. DERAAD

Notary Public,

Macomb County, Mich.

Acting in Wayne County, Mich.

My Commission Expires February 9, 1985

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF MICHIGAN  
SOUTHERN DIVISION

No. 82-40304

Hon. Stewart A. Newblatt

ARTHUR TAYLOR,  
vs. *Plaintiff,*

GENERAL MOTORS CORPORATION, and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Defendants.*

ANSWER OF METROPOLITAN  
LIFE INSURANCE COMPANY  
TO PLAINTIFF'S FIRST  
AMENDED COMPLAINT

NOW COMES the above named Defendant, Metropolitan Life Insurance Company, by and through its attorneys, RUBENSTEIN PRUCHNICKI, CHITTLE & SMITH, by Gilbert Y. Rubenstein, and in answer to Plaintiff's First Amended Complaint says paragraph by paragraph as follows:

COUNT I

*PUBLIC POLICY TORTS*

1.-19. Paragraphs 1 through 19 of Count I of Plaintiff's First Amended Complaint are all directed to his action against General Motors Corporation and do not require an answer by this Defendant.

COUNT II

*BREACH OF INSURANCE CONTRACT*

1. Admitted, upon information and belief.
2. Admitted, upon information and belief.

3. This Defendant admits only that the Plaintiff alleges that there is an amount in controversy in excess of \$10,000.00; it neither admits nor denies any inference therefrom.

4.-19. This Defendant neither admits nor denies the allegations contained in Paragraphs 4-19 of Count I, having insufficient knowledge or information to form a belief as to the truth of the allegations and leaves Plaintiff to his proofs thereon.

20. This Defendant reasserts its foregoing answers in answer to Paragraph 20 of Count II of Plaintiff's First Amended Complaint.

21. This Defendant neither admits nor denies the allegation contained in Paragraph 21 of Count II, having insufficient knowledge or information to form a belief as to the truth of the allegations and leaves Plaintiff to his proofs thereon; further answering, this Defendant affirmatively shows unto the Court that it did issue to General Motors Corporation certain group policies of insurance covering its salaried employees and under which the Plaintiff was covered for certain insurance benefits through November 5, 1980, upon which date his said insurance coverage terminated coincident with the date of the termination of his employment with General Motors Corporation.

22. This Defendant admits that the premium for said insurance policies were paid by General Motors Corporation and that said policies of insurance insured eligible salaried employees of General Motors Corporation during the period of their employment pursuant to the terms, conditions and provisions of said group policies of insurance.

23. Answering Paragraph 23 of Count II, this Defendant admits the issuance to General Motors Corporation of the group policies described therein to cover its salaried employees.

24. Answering Paragraph 24 of Count II, this Defendant admits that its group policy No. 18501-G provided for the payment of monthly disability insurance benefits to those salaried employees of General Motors Corporation who by its terms, conditions and provisions would be entitled thereto.

25. This Defendant neither admits nor denies what the 1980 General Motors Personal Benefit Summary stated, having insufficient knowledge or information to form a belief as to the truth of the allegations and leaves Plaintiff to his proofs thereon; further answering, this Defendant affirmatively shows unto the Court that the monthly sickness and accident insurance benefit is in an amount equal to three-quarters of the employee's monthly base salary subject to his entitlement thereto and subject to certain reductions, all as provided under the terms, conditions and provisions of said group policy.

26. Answering Paragraph 26 of Count II of Plaintiff's First Amended Complaint, this Defendant admits that the group policy which provides sickness and accident (disability) insurance was in effect for Plaintiff on July 30, 1980, but denies that Plaintiff was then totally disabled for the reason that this allegation is not true; this Defendant neither admits nor denies that Plaintiff was dependent on said insurance for his entire income having insufficient knowledge or information to form a belief as to the truth of the allegation and leaves Plaintiff to his proofs thereon; this Defendant denies that it wrongfully and maliciously discontinued said insurance coverage for the reason that this allegation is not true; further answering, this Defendant affirmatively shows unto the Court that it only discontinued payment of said month disability insurance benefits on the aforementioned date after it had received the reports of two medical specialists who found, after examination of Plaintiff, that he was able to work.

27. The allegations contained in Paragraph 27 of Count II are denied because they are not true.

28. This Defendant neither admits nor denies the allegation of Paragraph 28 of Count II having insufficient knowledge or information to form a belief as to the truth of the allegation and leaves Plaintiff to his proofs thereon.

29. This Defendant denies that it improperly discontinued payment of the monthly disability insurance benefits to Plaintiff because it is not true; as to the remaining allegations contained in Paragraph 29 of Count II, it neither admits nor denies the allegations having insufficient knowledge or information to form a belief as to the truth of the allegations and leaves Plaintiff to his proofs thereon.

30. This Defendant neither admits nor denies the allegation of Paragraph 30 of Count II having insufficient knowledge or information to form a belief as to the truth of the allegation and leaves Plaintiff to his proofs thereon.

31. This Defendant neither admits nor denies the allegation of Paragraph 31 of Count II having insufficient knowledge or information to form a belief as to the truth of the allegation and leaves Plaintiff to his proofs thereon.

#### AFFIRMATIVE DEFENSES

1. Plaintiff's First Amended Complaint fails to state a claim, in whole or in part, upon which relief may be granted.

2. Plaintiff fails to state a claim upon which relief may be granted in part because Plaintiff may not recover extra-contractual damages, whether compensatory, exemplary, punitive, mental anguish or however described.

3. Plaintiff has failed to meet the conditions precedent to recovery under the policy of insurance described in Plaintiff's First Amended Complaint.

4. This Defendant reserves the right to file such other affirmative defenses as may be hereafter discovered and is applicable.

WHEREFORE, this Defendant, Metropolitan Life Insurance Company, prays that this Court strike Plaintiff's claim for compensatory, exemplary and/or punitive damages or that it dismiss said claim for compensatory, exemplary and/or punitive damages; and as to Plaintiff's claim for the contractual insurance benefits, that his complaint be dismissed or in the alternative, that a judgment of no cause for action be entered against Plaintiff and in favor of this Defendant, together with costs and attorney fees.

### COUNT III

#### BREACH OF EMPLOYMENT CONTRACT

32.-38. Paragraphs 32-38 of Count III of Plaintiff's First Amended Complaint are all directed to his action against General Motors Corporation and do not require an answer by this Defendant.

RUBENSTEIN PRUCHNICKI CHITTLE  
& SMITH  
Attorneys for the Defendant,  
Metropolitan Life Insurance  
Company

By: /s/ Gilbert Y. Rubenstein  
GILBERT Y. RUBENSTEIN

Dated: 10/31/83

RUBENSTEIN PRUCHNICKI CHITTLE & SMITH  
Attorneys at Law  
By: Gilbert Y. Rubenstein  
1221 Beach Street,  
Flint, Michigan 48502  
Phone: (313) 767-2520

GM

### GENERAL MOTORS CORPORATION

October 20, 1983

Clerk of the Court  
United States District Court  
Eastern District of Michigan  
Federal Building  
600 Church Street  
Flint, Michigan 48502

Re: *Arthur Taylor v. General Motors  
Corporation and Metropolitan Life  
Insurance Company*, No. 81-40304

Dear Sir:

Regarding the above matter, enclosed please find the original and one copy of the Answer of General Motors Corporation to Plaintiff's First Amended Complaint, together with a Certificate of Service. Please file accordingly.

Very truly yours,

David M. Davis  
Senior Counsel  
Personnel and Labor Relations  
Legal Staff

DMD/bkh

cc: James A. Brescoll, Esq.  
Gilbert Y. Rubinstein, Esq.

General Motors Building 3044 West Grand Boulevard  
Detroit, Michigan 48202

## SUPREME COURT OF THE UNITED STATES

---

 No. 85-686

 METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioner*

v.

ARTHUR TAYLOR

---

 ORDER ALLOWING CERTIORARI  
 FILED FEBRUARY 24, 1986
 

---

The petition herein for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit is granted. This case is consolidated with 85-688, *General Motors Corporation v. Arthur Taylor*, and a total of one hour is allotted for oral argument.

## SUPREME COURT OF THE UNITED STATES

---

 No. 85-688

 GENERAL MOTORS CORPORATION,  
*Petitioner*

v.

ARTHUR TAYLOR

---

 ORDER ALLOWING CERTIORARI  
 FILED FEBRUARY 24, 1986
 

---

The petition herein for a writ of certiorari to the United States Court of Appeals for the Sixth Circuit is granted. This case is consolidated with 85-686, *Metropolitan Life Insurance Company v. Arthur Taylor*, and a total of one hour is allotted for oral argument.

•



**PETITIONER'S**  
**BRIEF**

3 6  
Nos. 85-686 and 85-688

Supreme Court, U.S.

FILED

MAY 2 1986

JOSEPH E. SPANIOLO, JR.  
CLERK

IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1985

GENERAL MOTORS CORPORATION and  
METROPOLITAN LIFE INSURANCE COMPANY,  
v. *Petitioners,*

ARTHUR TAYLOR,  
*Respondent.*

On Writs of Certiorari to the United States  
Court of Appeals for the Sixth Circuit

BRIEF FOR PETITIONERS  
GENERAL MOTORS CORPORATION AND  
METROPOLITAN LIFE INSURANCE COMPANY

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(202) 828-5000*

### QUESTION PRESENTED

Whether a claim filed in state court for disability benefits under an employee welfare benefit plan covered by the Employee Retirement Income Security Act of 1974 is a claim which arises under federal law by reason of federal preemption, or which falls within the original jurisdiction of the district court by reason of an express grant of jurisdiction, so that it may properly be removed to the district court pursuant to 28 U.S.C. 1441.

# **RULE 28.1 STATEMENT**

General Motors Corporation's subsidiaries and affiliates, other than wholly-owned subsidiaries and affiliates, are as follows:

Aralmex, S.A. de C.V. (Mexico)  
 Automotriz Gencor, S.A. (Ecuador)  
 Autos y Maquinas del Ecuador, S.A. (AYMESA)  
 (Ecuador)  
 Comanis Nacional de Direcciones Automotrices,  
 S.A. de C.V. (Mexico)  
 Compresores Delfa, C.A. (Venezuela)  
 Convesco Vehicle Sales GmbH (West Germany)  
 Daewoo Motor Co., Ltd. (Korea)  
 DHB-Componentes Automotives, S.A. (Brazil)  
 Fabrica Columbians de Automotores, S.A.  
 ("Colomotores") (Colombia)  
 General Motors de Colombia, S.A. (Colombia)  
 General Motors Egypt, S.A.E. (Egypt)  
 General Motors Iran Limited (Iran)  
 General Motors Kenya Limited (Kenya)  
 GM Allison Japan Limited (Japan)  
 GM Fanuc Robotics Corp. (USA)  
 Industries Mecaniques Meghrebires, S.A. (Tunisia)  
 Industrija Delova Automobils, Kikinda  
 (Yugoslavia)  
 Isuzu Motors Limited (Japan)  
 Isuzu Motors Overseas Distribution Corp. (Japan)  
 Kabelwerke Reinshagen GmbH (West Germany)  
 Kabelwerke Reinshagen Werk Berlin GmbH (West  
 Germany)  
 Kabelwerke Reinshagen Werk Neumarkt GmbH  
 (West Germany)  
 Moto Diesel Mexicana, S.A. de C.V. (Mexico)  
 Motor Enterprises, Inc. (USA)

Omnibus BB Transportes, S.A. (Ecuador)  
 Promotorade Partes Electronicas Automotrices  
 (Mexico)  
 P.T. Mesin Isuzu Indonesia (Indonesia)  
 Senalizacion y Accesorios del Automobile Yorka,  
 S.A. (Spain)  
 Unicables, S.A. (Spain)

Metropolitan Life Insurance Company's subsidiaries and affiliates, other than wholly-owned subsidiaries and affiliates, are as follows:

Met-West Agribusiness, Inc.

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IN THE  
Supreme Court of the United States

OCTOBER TERM, 1985

Nos. 85-686 and 85-688

GENERAL MOTORS CORPORATION and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioners.*

v

ARTHUR TAYLOR,  
*Respondent.*

**On Writs of Certiorari to the United States  
Court of Appeals for the Sixth Circuit**

**BRIEF FOR PETITIONERS  
GENERAL MOTORS CORPORATION AND  
METROPOLITAN LIFE INSURANCE COMPANY**

### OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-8a)<sup>1</sup> is reported at 763 F.2d 216. The order of the district court denying a motion to remand this case to state court (Pet. App. 9a) is unreported. The district court's memorandum opinion and order deciding the case on the merits (Pet. App. 10a-19a) is reported at 588 F. Supp. 562.

<sup>1</sup> "Pet. App." refers to the appendix to the petition for certiorari filed by General Motors Corporation.

## JURISDICTION

The judgment of the court of appeals (Pet. App. 1a) was entered on June 7, 1985. A timely petition for rehearing with suggestion for rehearing *en banc* was denied on July 25, 1985 (Pet. App. 20a). The petitions for certiorari in this case were filed on October 22 and 23, 1985, and were granted on February 24, 1986 (J.A. 268-9). The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

## STATUTORY PROVISIONS INVOLVED

This case involves the Employee Retirement Income Security Act of 1974, "ERISA," 29 U.S.C. 1001 *et seq.*, and the federal removal statute, 28 U.S.C. 1441 (a), (b), and (c). The relevant statutory provisions are set forth in the Appendix to this brief.

## STATEMENT

Respondent Arthur Taylor ("Taylor") filed this suit in state court against petitioners General Motors Corporation ("General Motors") and Metropolitan Life Insurance Company ("Metropolitan Life"), seeking, *inter alia*, relief for alleged wrongful termination of disability benefits provided under an ERISA-covered employee welfare benefit plan. The district court concluded that such a suit was properly removable to federal court under 28 U.S.C. 1441. The court of appeals reversed, concluding that the case was not removable.

### A. The General Motors Insurance Program for Salaried Employees

General Motors maintains the General Motors Insurance Program for Salaried Employees to provide benefits to eligible disabled salaried employees. Under this program, an employee can receive both Sickness and Accident Benefits and Salary Continuation Benefits during

the first twelve months of disability. Thereafter, eligible employees with substantial service records are entitled to receive Extended Disability Benefits until age 65.

During the time period relevant to this case, Sickness and Accident Benefits and Extended Disability Benefits were provided by General Motors under a certificate of insurance issued by Metropolitan Life. J.A. 162-232. Although those benefits were provided through Metropolitan Life, the premium paid by General Motors to the insurance company was based on the disability experience of General Motors employees and premium rates were experience rated. As the court of appeals recognized (Pet. App. 4a), "[t]he group insurance policy at issue in this case is part of GMC's employee benefits program established under ERISA."

During the relevant time period, the Salary Continuation Benefits that General Motors provided for eligible disabled employees were self-funded by General Motors. J.A. 46. They were administered solely by General Motors and payments were made from current assets of the company. *Id.* at 46.

The summary plan booklet which describes the General Motors Insurance Program for Salaried Employees, including Sickness and Accident Benefits, Extended Disability Benefits, and Salary Continuation Benefits, specifies that "[t]he Finance Committee of General Motors Corporation is the named fiduciary of the plans described in this booklet." J.A. 155. The booklet further provides that "General Motors Corporation is the sponsoring employer and administrator of the benefit plan described in this booklet." *Id.* at 155.

### B. Taylor's Claim For Benefits

Respondent Arthur Taylor commenced employment with General Motors in June 1959. In May 1980, he

took a sick leave and filed a claim for Sickness and Accident Benefits and Salary Continuation Benefits under the General Motors Insurance Program for Salaried Employees. He received both kinds of disability benefits from May 21, 1980 through July 30, 1980. Pet. App. 2a-3a, 28a.

Metropolitan Life monitored Taylor's claim for disability benefits and requested two medical specialists to examine him to determine his continued eligibility. Taylor was initially examined by a specialist in psychiatry who found he "was not disabled and could return to work." Pet. App. 3a. Subsequently, he was examined by an orthopedic specialist who concluded that he "suffered no orthopedic problems." *Ibid.* Based on these medical findings, Taylor's disability benefits were discontinued.

In October 1980, Taylor was requested to report to a General Motors medical department for examination. After that examination, it was concluded that he was able to resume the duties of his occupation. Pet. App. 3a. Taylor did not, however, return to work. Accordingly, in November 1980 General Motors notified him that he was considered to be a "voluntary quit" and that his employment was being terminated. *Ibid.*

### C. Taylor's Lawsuit

In March 1981, Taylor brought suit against General Motors and Metropolitan Life in the Circuit Court for Wayne County, Michigan. His original complaint (Pet. App. 24a) alleged that his disability benefits had been "wrongfully \* \* \* discontinued" and demanded "immediate reimplementa-tion of all benefits," including "salary continuation" and "disability benefits." The complaint sought not only a continuation of such benefits but also

compensation for alleged "mental anguish caused by breach of this contract." *Id.* at 27a-28a.<sup>2</sup>

With Metropolitan Life's concurrence, General Motors removed Taylor's lawsuit to the United States District Court for the Eastern Division of Michigan. General Motors recited in its removal petition (Pet. App. 30a-33a) that Taylor's claim for benefits under the General Motors plan was a claim covered by ERISA. General Motors further asserted that the district court had removal jurisdiction under Section 502 of ERISA, 29 U.S.C. 1132, and the federal removal statute, 28 U.S.C. 1441. Section 502 of ERISA expressly vests the federal district courts with original jurisdiction over any claim to "recover benefits" under an ERISA-covered plan, and the federal removal statute expressly authorizes removal of any claim falling within the district court's original jurisdiction. Following briefing and argument, the district court (per Judge Joiner) denied Taylor's motion to remand the suit to state court. Pet. App. 9a.

In May 1984, the district court granted summary judgment and dismissed Taylor's complaint on the merits.<sup>3</sup> Pet. App. 10a-19a. In its opinion, the district court noted that General Motors had "properly removed the case to this court, citing the Employee Retirement Income Secu-

<sup>2</sup> Taylor's complaint further alleged that General Motors had wrongfully failed to promote him and had terminated his employment in retaliation for filing workers' compensation claims. Pet. App. 26a.

<sup>3</sup> Having decided that Taylor's complaint was properly removed under ERISA, the district court had discretion under the pendent jurisdiction doctrine to rule upon Taylor's state (non-ERISA) claims as well as his federal claims. *United Mine Workers v. Gibbs*, 383 U.S. 715 (1966); *In Re Romulus Community Schools*, 729 F.2d 431, 440 (6th Cir. 1984); 28 U.S.C. 1441(c). See footnote 2, *supra*.

rity Act, 29 U.S.C. 1132(a), as the basis of jurisdiction." *Id.* at 11a.

In June 1985, the United States Court of Appeals for the Sixth Circuit reversed the district court's judgment, concluding that Taylor's complaint had been improperly removed. Accordingly, the court of appeals remanded the case with instructions to transfer it back to state court. Pet. App. 8a.

In its opinion, the court of appeals observed that Taylor had "confined his claim \* \* \* to one based on state law." *Id.* at 6a. Accordingly, the court concluded, "the well-pleaded complaint rule preclude[d] removal." *Ibid.* In response to General Motors' and Metropolitan Life's contention that ERISA preempts state law and provides an exclusive federal remedy in cases of this kind, the court of appeals stated that it "is not 'clearly established' that actions for benefits allegedly due under a group insurance policy 'necessarily' arise under federal law simply because the insurance policy is part of an overall benefit plan established pursuant to ERISA." *Id.* at 7a.

The court of appeals recognized that "as a general rule courts permit removal to federal court, notwithstanding the well-pleaded complaint doctrine, where an employee in a labor case attempts to assert a common law cause of action against his employer." Pet. App. 8a. The court also acknowledged that "[i]n those cases \* \* \* regardless of the wording of the complaint it is clear that the claim must necessarily arise under federal law." However, the court of appeals believed that "cases implicating ERISA \* \* \* differ from those involving the federal labor laws generally." *Ibid.*

## SUMMARY OF ARGUMENT

### I.

Although the court of appeals characterized Taylor's claim as a "state law" claim for disability benefits, the court overlooked the fact that ERISA has fundamentally transformed the nature of Taylor's claim. Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), Congress has expressly preempted and superseded the state law cause of action otherwise available to Taylor. And under Section 502 of ERISA, 29 U.S.C. 1132, Congress has expressly vested the federal district court with original jurisdiction to adjudicate his claim for benefits.

ERISA's legislative history establishes that these provisions mandate the application of a uniform body of federal law to determine the rights of participants under ERISA-covered plans. In unambiguous terms, Congress has declared that "[a]ll such actions" are to be "regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947." H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 327, reproduced in 3 U.S. Code Cong. & Admin. News 5038, 5107 (1974) (emphasis supplied).

Recent opinions of this Court, such as *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), and *Shaw v. Delta Airlines*, 463 U.S. 85 (1983), confirm the broad sweep of ERISA's preemption of state law. Other recent opinions of the Court, such as *Massachusetts Mutual Life Insurance Co. v. Russell*, — U.S. —, 105 S. Ct. 3085, 3097 (1985) (concurring opinion), confirm that Congress intended federal district courts to apply "federal common law" in resolving claims such as those asserted by Taylor.

## II.

Because Congress has provided that Taylor's claim falls within the original jurisdiction of the district court and has further provided that Taylor's claim arises under federal law, the present case is removable to district court under the unambiguous terms of 28 U.S.C. 1441(a) and (b).

In a case such as this, the "well pleaded complaint" doctrine does not restrict removal. Here, as in *Avco Corporation v. Aero Lodge No. 735*, 390 U.S. 557, 560 (1968), federal law has completely superseded state law. Accordingly, even though Taylor does not explicitly mention federal law in his complaint, "[r]emoval is but one aspect of 'the primacy of the federal judiciary in deciding questions of federal law.'"

This Court's decision in *Franchise Tax Board v. Construction Laborers Trust*, 463 U.S. 1, 24 (1983), supports the propriety of removal in a case such as this one. Although removal was disapproved in that case because ERISA served only as a "defense" to a state law complaint, this Court adhered to the principle that "if a federal cause of action completely preempts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law" and is removable to the district court. That principle applies directly here.

## III.

Taylor nonetheless relies on the Fifth Circuit's recent decision in *Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311 (5th Cir. 1985), *petition for cert. pending*, No. 85-1043, as a ground for opposing removal. *Pilot Life* held that ERISA does not preempt common law causes of action seeking benefits under "insured" employee benefit plans. In so ruling, the Fifth Circuit cited ERISA's so-

called "insurance saving clause," Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), which saves from federal preemption any state law which "regulates insurance." In fact, however, *Pilot Life* offers no support for Taylor's position. *Pilot Life* was incorrectly decided and, in any event, is irrelevant to the removal issue presented in this case.

The Fifth Circuit erred in *Pilot Life* when it concluded that a state law cause of action, which is based on common law doctrines of general applicability, is a state law which "regulates insurance" within the meaning of the insurance saving clause. The insurance saving clause, like the McCarran-Ferguson Act, saves from preemption state laws that apply specifically to insurers and insurance contracts. As its literal language indicates, the insurance saving clause does not save from federal preemption common law principles which do not apply in particular to the business of insurance, but rather apply generally to all contracting parties and all types of contracts.

More fundamentally, *Pilot Life* overlooked the critical fact that the insurance saving clause does not preserve state law which applies "directly" to employee welfare benefit plans. As this Court concluded in *Metropolitan Life Ins. Co. v. Massachusetts*, — U.S. —, 105 S. Ct. 2380, 2390 (1985), the insurance saving clause does *not* save state "laws regulating insurance contracts that apply directly to benefit plans." Permitting plan participants such as Taylor to bring state law suits to contest the denial of benefits under ERISA plans would constitute "direct" state law regulation of those plans of a most harmful and intrusive sort.

Beyond this, regardless of the ultimate resolution of the preemption issue raised in *Pilot Life*, the present case

is clearly removable to federal court because it falls within the district court's "original jurisdiction." Congress has expressly provided in Section 502 of ERISA, 29 U.S.C. 1132, that Taylor's claim "to recover benefits" under an ERISA-covered plan falls within the jurisdiction of the district court, regardless of the amount in controversy or the citizenship of the parties. That alone suffices to support removal pursuant to 28 U.S.C. 1441(a) and (b).

*Pilot Life* also is no obstacle to removal here because Taylor's complaint contains a claim for uninsured salary continuation benefits. Plainly, claims for such uninsured benefits are not subject to the insurance saving clause and are preempted by ERISA. Accordingly, Taylor's separate claim for uninsured salary continuation benefits necessarily arises under federal law and supports removal of his entire complaint pursuant to 28 U.S.C. 1441(c).

#### ARGUMENT

#### **TAYLOR'S CLAIM FOR BENEFITS UNDER AN ERISA-COVERED EMPLOYEE WELFARE BENEFIT PLAN IS REMOVABLE FROM STATE COURT BECAUSE IT ARISES UNDER FEDERAL LAW AND FALLS WITHIN THE ORIGINAL JURISDICTION OF THE DISTRICT COURT.**

The court of appeals reasoned that because Taylor's complaint purports to allege a state law cause of action, the "well-pleaded complaint rule" bars removal. The court failed to recognize, however, that ERISA preempts Taylor's state law cause of action and replaces it with a federal cause of action which district courts are expressly empowered to adjudicate. Like an employee's claim under a collective bargaining agreement, Taylor's claim for disability benefits under an ERISA-covered plan arises under federal law and falls within the original jurisdiction

of the district court whether or not he relies on federal law in drafting his complaint.

ERISA is not simply a "defense" to Taylor's state law cause of action. ERISA has supplanted any state law cause of action with a cause of action that is exclusively federal in nature, and has conferred original jurisdiction on the district court to determine the merits of Taylor's claim. As numerous federal courts have held, including the Ninth Circuit in *Clorox v. District Court*, 779 F.2d 517, 521 (1985), and the Tenth Circuit in *Roe v. General American Life Insurance Company*, 712 F.2d 450, 452 (1983), cases such as this are removable under the unambiguous terms of the federal removal statute, which permits removal of "any" civil action "of which the district courts of the United States have original jurisdiction," and "any" civil action founded on a claim "arising under \* \* \* the laws of the United States." 28 U.S.C. 1441(a), (b).

#### **I. ERISA Preempts Taylor's State Law Cause Of Action And Replaces It With A Federal Cause Of Action Which The District Court Is Expressly Empowered To Adjudicate.**

The literal language of ERISA, the legislative history, and past decisions of this Court defining the preemptive impact of ERISA combine to demonstrate that Taylor's cause of action is exclusively federal in nature and falls within the district court's original jurisdiction.

#### **A. The literal terms of Sections 502 and 514 of ERISA establish that Taylor's state law cause of action has been superseded by a federal cause of action.**

The General Motors Insurance Program for Salaried Employees is plainly an "employee welfare benefit plan" as defined in Sections 3(1) and 4(a)(1) of ERISA. It was established by General Motors, an employer "en-

gaged in commerce," for the purpose of providing, "through the purchase of insurance or otherwise," "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, [or] disability." 29 U.S.C. 1002(1), 1003(a)(1).

In broad and unambiguous terms, Congress has preempted all state law causes of action relating to such employee welfare benefit plans. Section 514(a) of ERISA, 29 U.S.C. 1144(a), specifies that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" subject to the statute.<sup>4</sup> The state laws so preempted include "all laws, decisions, rules, regulations, or other State action \* \* \*" which "purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter." Section 514(c)(1), (2), 29 U.S.C. 1144(c)(1), (2).

Congress did not, however, merely displace state law claims for ERISA benefits. At the same time that it preempted state law, it fashioned a comprehensive array of new federal remedies. As stated in ERISA's declaration of purpose, Congress intended not only to establish federal "standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans," but also to provide "appropriate remedies, sanctions, and ready access to the Federal courts." Section 2(b), 29 U.S.C. 1001(b) (emphasis supplied).

These new federal causes of action are delineated in Section 502 of ERISA, 29 U.S.C. 1132. That provision prescribes six carefully-integrated civil enforcement provisions under which participants and beneficiaries may enforce the responsibilities of fiduciaries administering

<sup>4</sup> The limited exceptions to this broad preemption provision are discussed on pages 31-42, *infra*.

employee welfare benefit plans. Of particular relevance is Section 502(a)(1)(B), which authorizes any "participant," such as Taylor, to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan \* \* \*." Congress expressly vested federal courts with original jurisdiction to entertain such suits. Section 502(e)(1) of ERISA provides that "district courts of the United States," in addition to the state courts, shall have "jurisdiction of actions under subsection (a)(1)(B) of this section." And Section 502(f) of ERISA further provides that district courts "shall have jurisdiction without respect to the amount in controversy or the citizenship of the parties."

In short, ERISA's literal language demonstrates that Congress preempted state law claims of the kind asserted by Taylor and replaced them with a new federal cause of action. At the same time, Congress expressly defined the original jurisdiction of the district courts to encompass complaints such as Taylor's complaint which alleges "improper discontinuance of \* \* \* benefits" under an ERISA-covered plan (Pet. App. 28a-29a).

***B. The legislative history of ERISA confirms that Taylor's state law cause of action has been preempted and replaced by a federal cause of action.***

ERISA's legislative history confirms that, subject to certain narrow exceptions set forth in the statute, Congress intended to preempt all state law relating to employee welfare benefit plans. As explained by Rep. Dent, the Chairman of the Subcommittee on Labor of the House Labor and Education Committee: "I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority of the

sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong. Rec. 29197 (1974). The legislative history clearly demonstrates that Congress, in enacting ERISA, intended to replace the conflicting system of state and local regulation of employee benefit plans with a "uniform source of law" for evaluating the conduct of plan administrators. Introductory Statement of Sen. Javits on S. 1557, reprinted in 1 *Legislative History of ERISA* 273, 279 (1973); accord, 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); *id.* at 29197 (remarks of Rep. Dent). In so acting, Congress sought to enable fiduciaries administering multi-state plans to "predict the legality of proposed actions without the necessity of reference to varying state laws." H.R. Rep. No. 93-533, 93 Cong., 1st Sess. 12 (1973), reprinted in 2 *Legislative History of ERISA* 2359; see also 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits).

As explained by Sen. Williams, the Chairman of the Committee on Labor and Public Welfare from which ERISA emanated, both the "substantive" and "enforcement" provisions of ERISA were designed to supersede state law:

It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulation, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 Cong. Rec. 29933 (1974). In the words of Senator Javits, one of the two principal Senate sponsors of ERISA, "[i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29942 (1974). Senator Williams, the other principal Senate sponsor of ERISA, likewise emphasized that suits involving claims for benefits "will be regarded as arising under the laws of the United States, in similar fashion to those brought under Section 301 of the Labor Management Relations Act." *Id.* at 29933.

In sum, as pointed out by the Conference Report which immediately preceded enactment of ERISA, "suits to enforce benefit rights under the plan or to recover benefits under the plan" arise under *federal* law whether filed in state or federal court: "All such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor Management Relations Act of 1947." H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 327, reproduced in 3 U.S. Code Cong. & Admin. News 5038, 5107 (1974).

***C. Past decisions of this Court and the lower federal courts confirm that Taylor's state law cause of action has been preempted and replaced by a federal cause of action.***

Past decisions of this Court and the lower federal courts repeatedly have recognized that ERISA preempts state law relating to employee benefit plans and provides a new federal cause of action for plan participants. This Court explained the breadth of federal preemption in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), which struck down a state statute that inter-

ferred with the calculation of ERISA benefits. Referring to ERISA's broad preemption provision, the Court stated: "This provision demonstrates that Congress intended to depart from its previous legislation that 'envisioned the exercise of state regulation power over pension funds,' \* \* \* and meant to establish pension plan regulation as exclusively a federal concern." *Id.* at 523. The Court concluded that a state law relating to ERISA plans is preempted even if it "is in no way concerned with pension plans *qua* pension plans." *Id.* at 524. The Court added (*id.* at 525):

It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern. \* \* \* ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision.

This Court again addressed ERISA's preemption provision in *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983), which held that state employment discrimination laws imposing requirements more onerous than federal law could not be applied to an ERISA-covered benefit plan. The Court observed that a state law "relates" to an employee benefit plan, and accordingly is preempted by ERISA, if "it has a connection with or reference to such a plan." *Id.* at 97. This broad construction "is entirely consistent with Congress' goal of ensuring that employers would not face 'conflicting or inconsistent State and local regulation of employee benefit plans.'" *Id.* at 105.

ERISA's impact on suits seeking recovery of employee benefits is illustrated by this Court's decision in *Massachusetts Mutual Life Insurance Co. v. Russell*, — U.S.

—, 105 S. Ct. 3085 (1985). In *Russell*, as in the present case, the plan participant commenced suit in state court seeking damages based on denial of benefits under an ERISA-covered employee welfare plan. As in the present case, the employee's initial complaint relied solely on state law principles.

The defendant in *Russell* removed the suit to federal court, asserting that the employee's claim arose under federal law by virtue of ERISA. The district court sustained removal, concluding "that ERISA governed Russell's claims relating to the benefit plan and preempted all state actions relating to those claims." 722 F.2d 482, 485. The Ninth Circuit affirmed on the preemption issue, observing that "Russell's state law causes of action based on Mutual's handling of her disability claim are preempted by ERISA." *Ibid.*

This Court granted certiorari in *Russell* to consider whether the plan participant could recover extra-contractual compensatory or punitive damages caused by improper processing of benefit claims. In rejecting the plan participant's claim, this Court referred to the "six carefully-integrated civil enforcement provisions" set forth in ERISA, and observed that "Congress did *not* intend to authorize other remedies." 105 S. Ct. at 3093 (emphasis in original). In words that are directly applicable here, the Court stressed that a plan participant has an explicit federal cause of action: "To recover the benefits due her, she could have filed an action pursuant to 502(a)(1)(B) to recover accrued benefits, to get declaratory relief that she is entitled to benefits under the provisions of the plan contract, and to enjoin the plan administrator from improperly refusing to pay benefits in the future." *Ibid.*

The concurring opinion in *Russell*, joined by Justices Brennan, White, Marshall and Blackmun, further ex-

plained the nature of a plan participant's cause of action. That opinion observed that Congress intended federal standards "to govern the ERISA claims-administration process." *Id.* at 3096. In particular, the "legislative history demonstrates that Congress intended federal courts to develop federal common law in fashioning \* \* \* 'appropriate equitable relief.'" *Id.* at 3097. Quoting the legislative history, the concurring opinion in *Russell* stressed that "suits involving beneficiaries' rights 'will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor-Management Relations Act.'" *Id.* at 3098; see also *id.* at 3098 n. 14.

Consistent with the principles stated in *Alessi*, *Shaw*, and *Russell*, the federal courts of appeals repeatedly have held that purported state law claims brought by plan participants are preempted and superseded by an exclusive federal cause of action. Most recently, in *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 421-422 (4th Cir. 1985), the court of appeals declared:

Given the "unparalleled breadth" of the preemption clause, \* \* \* and the broad remedial policy of ERISA, we hold that state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, "relate to" such plans and, absent an applicable exemption, are preempted by ERISA.

Other circuits have reached the same conclusion. See, e.g., *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320, 326-328 (2d Cir. 1985) ("state law causes of action" are "preempted" by ERISA when "based on claims for relief under the common law of contracts"); *Barrowclough v. Kidder, Peabody & Co., Inc.*, 752 F.2d 923, 936 (3d Cir. 1985) ("In enacting ERISA, Congress authorized the evolution of a federal common law of pen-

sion plans"); *Cowan v. Keystone Employee Profit Sharing Fund*, 586 F.2d 888, 893 (1st Cir. 1978) (finding that ERISA resulted in "federal displacement of state law \* \* \* with respect to any cause of action" arising after its effective date, and that participant suits "are to be treated as arising under federal law in the same manner as suits brought under Section 301 of the Labor Management Relations Act"); *Reiherzer v. Shannon*, 581 F.2d 1266, 1271 (7th Cir. 1978) ("federal jurisdiction exists over, and federal common law will govern, actions under section 502 claiming that pension trustees have improperly denied pension benefits").

Thus, the plain statutory language of ERISA, the legislative history, and past decisions of this Court and other courts, all demonstrate that claims brought by participants for benefits under ERISA-covered plans arise under and are governed by federal law. Such claims may be brought in either state or federal court, but in either case they are governed by federal law and are removable to federal court.

ERISA's preemptive impact in such cases derives from two sources. Section 514(a) of ERISA expressly preempts state law relating to employee welfare benefit plans. And Section 502(a)(1)(B) of ERISA expressly creates a federal cause of action modeled on the cause of action prescribed in Section 301 of the Labor-Management Relations Act, a cause of action which Congress fully recognized to be preemptive of state law. Each of these provisions is independently sufficient to preempt state law in a case such as this.

Acceptance of Taylor's contrary submission would negate the most fundamental purposes of ERISA. Acceptance of Taylor's theory would defeat Congress' purpose to establish a uniform body of federal law for evaluating

fiduciary conduct under ERISA, and would subvert the Congressional intent to empower plan administrators to provide uniform administration of multi-state plans and predict the legality of proposed actions without reference to varying state laws. It would subject the terms and conditions of plans to discrepant and conflicting interpretations in different jurisdictions, in derogation of the right of plan participants to fair and uniform treatment. In addition, recognition of a state law cause of action for plan participants would open the door to remedies destructive of federal policies of the very kind condemned in *Russell*, and would nullify the carefully constructed and comprehensive enforcement provisions of ERISA. This case exemplifies that danger. As in *Russell*, Taylor here is seeking to use state law remedies to recover extra-contractual "compensation for mental anguish caused by breach of this contract" in contravention of the policies of ERISA. Pet. App. 28a. These compelling practical considerations weigh heavily against acceptance of the view that Taylor retains "state claims" (Br. in Opp. 13) to challenge the administration of an ERISA-covered employee welfare benefit plan. See also pp. 37-42, *infra*.

**II. Because Taylor's Suit Necessarily Arises Under Federal Law And Falls Within The Original Jurisdiction Of The Federal District Court, It Is Properly Removable Under The Federal Removal Statute.**

Taylor's claim for benefits, purportedly arising under state law, has been preempted by ERISA, and is precisely the type of claim for which ERISA created a new federal cause of action. Taylor's cause of action is removable to federal district court for two independent reasons. First, it is a cause of action which Congress has placed within the "original jurisdiction" of the federal district courts, regardless of the amount in controversy or the citizenship of the parties. Second, it is a cause of action that

"arises under" federal law as a result of federal preemption. Either ground is independently sufficient to sustain removal under the federal removal statute, 28 U.S.C. 1441(a), (b).

The court of appeals declined to accept these conclusions for two reasons. First, the court asserted (Pet. App. 5a-6a) that because Taylor only relied on state law principles in his complaint, the "well-pleaded complaint rule" precluded removal. The court believed that ERISA is only a "defense" to Taylor's state law claim. Second, the court asserted (*ibid.*) that this Court's decision in *Franchise Tax Board v. Construction Laborers Trust*, 463 U.S. 1 (1983), stood as a barrier to removal. In fact, however, neither the "well-pleaded complaint rule" nor *Franchise Tax Board* precludes removal of a complaint seeking benefits under an ERISA-covered employee welfare benefit plan.

**A. The well-pleaded complaint doctrine does not preclude removal of a cause of action which falls within the original jurisdiction of the district court and which necessarily arises under federal law.**

A defendant may not remove a case to federal court unless the plaintiff's complaint shows that the case arises under federal law or falls within the district court's original jurisdiction. However, by the same token, the plaintiff cannot defeat removal merely by omitting to make reference to federal law which necessarily governs his complaint or by failing to recite that the district court is vested with original jurisdiction. In the present case, Taylor's assertion of state law contract claims cannot obscure the fact that his complaint falls squarely within the boundaries of Section 502 of ERISA. Congress has superseded all state remedies in the field and has left Taylor with only a federal cause of action. More-

over, Taylor's complaint discloses on its face that the present case falls squarely within the district court's original jurisdiction.

In these circumstances, it makes no difference that Taylor's complaint refers to state law rather than federal law. As this Court observed in *Federated Department Stores Inc. v. Moitie*, 452 U.S. 394, 397 n. 2 (1981), "courts 'will not permit [a] plaintiff to use artful pleading to close off defendant's right to a federal forum \* \* \*'"

If a federal cause of action completely preempts a state cause of action, any complaint falling within the scope of the federal cause of action necessarily arises under federal law and is properly removable. See, e.g., Comment, *Federal Preemption, Removal Jurisdiction, and the Well-Pleaded Complaint Rule*, 51 U. Chicago L. Rev. 634, 661, 666 (1984):

[W]here federal law has "completely preempted" the state law cause of action, it is proper to recharacterize the action as one that actually arises under federal law, despite the plaintiff's usual mastery over his complaint.

\* \* \*

If there is a superseding [federal] cause that concerns the same subject-matter as the state cause of action alleged in the complaint, then the state law cause of action certainly touches on areas of central concern to the federal law, and is within the preempted field.

Where federal law has preempted state law and created a federal remedy, federal law is not merely a "defense" to the state law claim. As Professor Wright has explained, "[f]ederal law in these labor cases is not merely a defense to a state contract theory, but is the basis of all rights of action under the contract. If state

law has been preempted in this sense, so that a state right of action has been replaced by a federal right of action, plaintiff necessarily is stating a federal claim whether he wishes to do so or not, and the case is removable." C. Wright, *The Law of Federal Courts*, 216 (4th ed. 1983).

The court of appeals did not disagree with the foregoing analysis. It recognized that "courts permit removal to federal court, notwithstanding the well-pleaded complaint doctrine, where an employee in a labor case attempts to assert a common law cause of action against his employer." It further recognized that in such cases "regardless of the wording of the complaint it is clear that the claim must necessarily arise under federal law. Any attempt by the plaintiff to circumvent federal labor law is merely a practice in artful pleading." The court refused to apply those principles here because it found "cases implicating ERISA to differ from those involving the federal labor laws generally." Pet. App. 8a. However, the court of appeals offered no reason to support such a distinction. And none exists.

On the contrary, when Congress enacted ERISA, it made clear that actions brought by plan beneficiaries for benefits under ERISA-covered plans were to be deemed, for jurisdictional purposes, equivalent to actions brought under the federal labor laws. See p. 15, *supra*. As explained in the Conference Report (H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 327 (1974), reprinted in 3 U.S. Code Cong. & Admin. News 5038, 5107 (1974)):

[C]ivil actions may be brought by a participant or beneficiary to recover benefits due under the plan, to clarify rights to receive future benefits under the plan and for relief from breach of fiduciary responsibility. \* \* \* All such actions in Federal or State

courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor Management Relations Act of 1947. The U.S. district courts are to have jurisdiction of these actions without regard to the amount in controversy and without regard to the citizenship of the parties.

See also *Massachusetts Mutual Life Insurance Company v. Russell*, *supra*, 105 S. Ct. at 3097-3098.

The unambiguous reference in ERISA's legislative history to Section 301 of the Labor Management Relations Act—a reference made in 1974—has decisive importance in this context in view of this Court's decision—in 1968—in *Avco Corporation v. Aero Lodge No. 735*, 390 U.S. 557 (1968).<sup>5</sup> In *Avco*, this Court held that Section 301 actions are controlled by federal substantive law and arise under the laws of the United States within the meaning of the federal removal statute. In words that apply directly here, the Court said in *Avco* (390 U.S. at 560):

An action arising under Section 301 is controlled by federal substantive law even though it is brought in a state court. *Humphrey v. Moore*, 375 U.S. 335; *Local 174 v. Lucas Flour Co.*, 369 U.S. 95; *Charles Dowd Box Co. v. Courtney*, 368 U.S. 502. Removal is but one aspect of "the primacy of the federal judiciary in deciding questions of federal law." See *England v. Medical Examiners*, 375 U.S. 411, 415-416. It is thus clear that the claim under this collective bargaining agreement is one arising under the "laws of the United States" within the meaning of the removal statute. 28 U.S.C. Section 1441(b). It

<sup>5</sup> When Congress cites an existing statute as a guide for interpreting new legislation, it is presumed to be aware of existing judicial constructions of that statute. See, e.g., *Lorillard v. Pons*, 434 U.S. 575, 581 (1978).

likewise seems clear that this suit is within the "original jurisdiction" of the District Court within the meaning of 28 U.S.C. Sections 1441(a) and (b). [Footnote omitted.]

In *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 23-24 (1983), this Court reaffirmed the *Avco* doctrine and explained that, when a federal statute supersedes state law, a claim for relief under state law necessarily "arises under" federal law:

The Court of Appeals [in *Avco*] held, 376 F.2d, at 340, and we affirmed, 390 U.S. at 560, that the petitioner's action "arose under" Section 301, and thus could be removed to federal court, although the petitioner had undoubtedly pleaded an adequate claim for relief under the state law of contracts and had sought a remedy available *only* under state law. The necessary ground of decision was that the pre-emptive force of § 301 is so powerful as to displace entirely any state cause of action "for violation of contracts between an employer and a labor organization." Any such suit is purely a creature of federal law, notwithstanding the fact that state law would provide a cause of action in the absence of § 301. *Avco* stands for the proposition that if a federal cause of action completely pre-empts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily "arises under" federal law.

Like actions brought under ERISA, actions brought under Section 301 may be filed either in a state or federal district court. *Charles Dowd Box Co. v. Courtney*, 368 U.S. 502 (1962). In either case, preemption protects the vital federal interest in uniform legal interpretation. *Allis-Chalmers Corporation v. Lueck*, — U.S. —, 105 S. Ct. 1904, 1911-1916 (1985); *Local 174 Teamsters v. Lucas Flour Co.*, 369 U.S. 95, 103-104 (1962) ("The im-

portance of the area which would be affected by separate systems of substantive law makes the need for a single body of federal law particularly compelling \* \* \*. State law which frustrates the effort of Congress to stimulate the smooth functioning of that process thus strikes at the very core of federal labor policy"). In sum, just as with Section 301, it is manifest that Congress mandated the development of a uniform body of federal law under ERISA, as to which "[r]emoval is but one aspect of 'the primacy of the federal judiciary in deciding questions of federal law.'" *Avco, supra*, 390 U.S. at 560.

Applying these principles, the courts of appeals repeatedly have held that the well-pleaded complaint doctrine does not bar removal when federal law has superseded a state law cause of action. See, e.g., *Olguin v. Inspiration Consolidated Copper Co.*, 740 F.2d 1468, 1472 (9th Cir. 1984) (the plaintiff cannot escape removal by "omitting from the complaint federal law essential to his claim, or by casting in state law terms a claim that can be made only under federal law"); *Eitmann v. New Orleans Public Service*, 730 F.2d 359, 366 (5th Cir. 1984) ("if a federal cause of action completely preempts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law"). See also *Hunter v. United Van Lines*, 746 F.2d 635, 642-643 (9th Cir. 1984), explaining that a state-law claim may be recharacterized as a federal claim for removal purposes when the "state-law claim is preempted by federal law and when it is apparent from a review of the complaint that federal law provides plaintiff a cause of action to remedy the wrong he asserts he suffered."

The foregoing principles, repeatedly announced by this Court and by the federal courts of appeals, confirm that

the "well-pleaded complaint rule" does not bar removal here. The failure of Taylor to mention federal law in his complaint does not alter the fact that his cause of action arises solely under federal law and falls squarely within the district court's original jurisdiction.

***B. This Court's decision in Franchise Tax Board supports the propriety of removal here.***

The court of appeals also found support (Pet. App. 6a) for its restrictive approach to removability in *Franchise Tax Board v. Construction Laborers Trust*, 463 U.S. 1 (1983). Far from supporting the court of appeals' approach, however, *Franchise Tax Board* clearly demonstrates why removal is proper here.

In *Franchise Tax Board*, a California agency sought to collect unpaid income taxes by levying on funds held in trust under an ERISA-covered vacation benefit plan. To enforce the levies, the Tax Board filed a complaint in state court based on state law. This Court held that the tax levy controversy was not removable. Significantly, however, the Court's opinion in *Franchise Tax Board* emphasized that an employee benefit suit would present issues far different from those presented by the tax levy controversy there before it. The Court pointed out that ERISA "contains provisions creating a series of express causes of action in favor of participants, beneficiaries, and fiduciaries of ERISA-covered plans \* \* \*." 463 U.S. at 24. The Court declared that "it may be that, as with Section 301 as interpreted in *Avco*, any state action coming within the scope of Section 502(a) of ERISA would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law." *Ibid.* The Court also emphasized that "ERISA's legislative history indicates that, in

light of the Act's virtually unique pre-emption provision \* \* \* 'a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.'" *Id.* at 24 n.26. Thus, *Franchise Tax Board* expressly recognized that, while a state's "right to enforce its tax levies is not of central concern to the federal statute" (*id.* at 25-26), an employee's right to obtain benefits under an ERISA plan clearly is.

Removal in *Franchise Tax Board* was held improper because the defendant merely asserted a *defense* based on federal law. The plaintiff's cause of action did not arise under federal law. As the Court explained, "ERISA does not provide an alternative cause of action in favor of the State to enforce its rights." *Id.* at 26. In the present case, by contrast, Taylor's claim for disability benefits obviously could have been brought under ERISA. Moreover, no matter how worded or disguised, Taylor's claim for benefits is necessarily a claim arising under ERISA, which preempts all state law in the field. As *Franchise Tax Board* confirms, such a suit may "be removed to federal court" even though the plaintiff "undoubtedly pleaded an adequate claim for relief under the state law of contracts and had sought a remedy available *only* under state law." *Id.* at 23 (emphasis in original).

Consistent with these principles, the great majority of lower court decisions have permitted removal even though the plaintiff fails to mention federal law when claiming benefits under an ERISA plan. See, e.g., *Clorox v. U.S. District Court*, 779 F.2d 517, 521 (9th Cir. 1985) ("Stower did not refer to ERISA in her complaint and she contends that remand was proper because she asserted only state claims. Stower's complaint includes, however, a claim that Clorox wrongfully and maliciously

denied her employment benefits. \* \* \* \* We have held that ERISA preempts state claims involving improper handling of claims for employee benefits. \* \* \* \* Therefore, removal of the 'denial of benefits' claim was proper"). Accord, *Roe v. General American Life Insurance Co.*, 712 F.2d 450, 452 (10th Cir. 1983); *Kilmer v. Central Counties Bank*, 623 F. Supp. 994, 997-1002 (W.D. Pa. 1985); *Tolson v. Retirement Committee of Briggs & Stratton*, 566 F. Supp. 1503, 1504 (E.D. Wis. 1983); *Calhoon v. Bonnabel*, 560 F. Supp. 101, 110 (S.D.N.Y. 1982); *McConnell v. Marine Engineers Beneficial Association*, 526 F. Supp. 770, 771-773 (N.D. Cal. 1981); *Buck v. Union Trustees Pension Fund*, 70 F.R.D. 530, 531 (E.D. Tenn. 1976); and *Leonardis v. Local 282 Pension Trust Fund*, 391 F. Supp. 554, 556-557 (E.D.N.Y. 1975).

These lower court decisions are important not only because their reasoning correctly reflects past decisions of this Court, but also because they accurately reflect Congressional intent. During the ten-year period in which these cases were decided, ERISA has been amended on several occasions, and Congress has never questioned or expressed disapproval of these rulings. In fact, Congress has expressed the view that federal court decisions permitting removal were correctly decided. See H.R. Rep. No. 94-1785, 94th Cong., 2d Sess. 49 (1977) (emphasis in original):

A significant volume of litigation relating to ERISA has developed in the 26 months since enactment. \* \* \* Procedural issues have been resolved, by and large, in accord with what might have been anticipated. *Leonardis v. Local 282 Pension Trust Fund*, 391 F. Supp. 544 (E.D.N.Y. 1975), held that a suit brought in *state* court under section 502(a)(1) of ERISA may be removed by the defendant to *federal*

district court. This holding merely clarified the proposition that even though state and federal courts have *concurrent* jurisdiction over actions brought to recover benefits, federal courts nonetheless have "original jurisdiction," as described in 28 U.S.C. Sec. 1337, over such suits and hence the federal courts have jurisdiction pursuant to 28 U.S.C. Sec. 1441.<sup>6</sup>

Congress' express recognition of a defendant's right to remove an employee benefit suit under ERISA is entitled to great weight. See *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 382 n.66 (1982); *United States v. Rutherford*, 442 U.S. 544, 554 n.10 (1979); *North Haven Board of Education v. Bell*, 456 U.S. 512, 535 (1982) (where a construction of a statute "has been 'fully brought to the attention of the public and the Congress, and the latter has not sought to alter the interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned' ").

In sum, the court of appeals plainly erred when it relied on the "well-pleaded complaint rule" and this Court's decision in *Franchise Tax Board* to defeat removal. The well-pleaded complaint rule does not preclude removal where Congress has preempted state law and provided a superseding federal cause of action which falls within the district court's original jurisdiction. And, far from casting doubt on removability, this Court's recent decision in *Franchise Tax Board* explains precisely why removal is proper here.

<sup>6</sup> This Court frequently has relied on the foregoing House Report in construing ERISA. See, e.g., *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.20 (1983).

### III. Taylor's Commencement Of Suit Against Both His Employer And The Insurance Company That Administered The Employee Welfare Benefit Plan Does Not Defeat Removal.

A final factor, mentioned by the court of appeals as weighing against removal, but not discussed by the court in any detail, was the presence of "insurance" in this case. Even though the court recognized that "the group insurance policy at issue in this case is part of GMC's employee benefits program established under ERISA," it asserted that "[i]t is not 'clearly established' that actions for benefits allegedly due under a group insurance policy 'necessarily' arise under federal law \* \* \*." Pet. App. 4a, 7a. Subsequent to the court of appeals' decision, the Fifth Circuit, in *Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311 (5th Cir. 1985), reached the conclusion that state common law claims seeking benefits under an "insured" ERISA plan were not preempted because of the "insurance saving clause" in ERISA, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A). The Fifth Circuit concluded that "state laws proscribing the same conduct as ERISA may provide a cause of action in place of, in addition to, or coequal with any cause of action available under ERISA." 770 F.2d at 1317. In so holding, the Fifth Circuit purported to rely on this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, — U.S. —, 105 S. Ct. 2380 (1985), which held that the insurance saving clause in ERISA saved from preemption a state insurance statute which regulated the contents of a group insurance policy, an area left unregulated by ERISA.

In his brief in opposition in this Court (at 10-11), Taylor argues that the Fifth Circuit's decision in *Pilot Life* is "favorable" to his position. In fact, however, *Pilot Life* offers no support for Taylor's contentions. Not only

was *Pilot Life* incorrectly decided, but, in addition, the holding in that case is irrelevant to the issue of removal before this Court.<sup>7</sup>

**A. *Pilot Life* was incorrectly decided and therefore does not preclude removal in this case.**

*Pilot Life* was incorrectly decided and therefore does not constitute authority for precluding removal in a case such as this one. Contrary to the conclusion reached in *Pilot Life*, state law claims for disability benefits under an ERISA-covered plan are preempted whether or not the plan is "insured." ERISA's insurance saving clause has no application to such claims because they are not based on state law which "regulates insurance" within the meaning of the insurance saving clause, because they do not fall within the area reserved for exclusive state regulation by the McCarran-Ferguson Act, and because adjudication of such claims would constitute forbidden "direct regulation" by the states of ERISA-covered plans.

**1. Common law doctrines of general applicability are not state laws which "regulate insurance" within the meaning of the insurance saving clause.**

The insurance saving clause provides that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A) (emphasis supplied). Giving these words their "common sense" meaning, as this Court consistently has done in construing ERISA

<sup>7</sup> A petition for certiorari (No. 85-1043) has been filed in the *Pilot Life* case. The petition and the brief *amicus curiae* filed by the American Council of Life Insurance and the Health Insurance Association explain in detail why the insurance saving clause has no bearing on a common law cause of action of the kind asserted by Taylor and why the Fifth Circuit's decision is in error.

(see, e.g., *Metropolitan Life, supra*, 105 S.Ct. at 2390), it is manifest from the words themselves that Congress intended to bring within the scope of the insurance saving clause state regulatory schemes specifically *applicable to insurance*, and not common law contract doctrines of general applicability. There is no support in the language of ERISA for the notion that the common law governing contracts, which would be equally available in any type of contract dispute, is a law which "regulates insurance" within the meaning of ERISA's insurance saving clause whenever an insurance company is named as defendant.

This Court's decision in *Metropolitan Life, supra*, 105 S. Ct. 2380, illustrates the kind of state regulation which is protected from preemption under the insurance saving clause. The issue in *Metropolitan Life* was whether a Massachusetts mandated benefit law which required all insurers to provide mental health care benefits was a law which regulated insurance within the meaning of the insurance saving clause. Giving the saving clause a literal and common sense reading, this Court concluded that the Massachusetts statute constituted a type of insurance regulation. The Massachusetts statute was specifically directed to the contents of insurance policies and to insurers. It "regulat[ed] the substantive terms of insurance contracts" and "impose[d] requirements only on insurers." *Id.* at 2391.

Unlike statutes specifically regulating the contents of insurance policies, however, the present case involves state common law applicable generally to parties to any form of contract. It would require a complete distortion of the statutory language used by Congress to extend the insurance saving clause to a common law breach of contract claim. See *Northeast Dep. ILGWU v. Teamsters Local No. 229*, 764 F.2d 147, 158 n.8 (3d Cir. 1985), observing

that "judge-made rules regarding interpretation of insurance contracts are not the kind of state insurance regulations that the Congress intended to preserve." See also *Benvenuto v. Connecticut General Life Insurance Co.*, No. 84-3601 (D.N.J. Feb. 11, 1986), slip op. 16-17: "I am satisfied that plaintiff's state law causes of action are not saved from preemption under the 'savings clause' found in Section 1144(b)(2)(A), which exempts from preemption 'any law of any state which *regulates* insurance.' A plain meaning, common sense analysis of the word 'regulate' precludes the clause's application here. \* \* \* [I]t is clear that state law actions in breach of contract, fraud and negligent mishandling of a claim do not operate to regulate insurance." <sup>8</sup>

In sum, ERISA's insurance saving clause should be read in a literal, common sense manner, and should be applied only to exercises of state power specifically directed to insurance contracts and the insurance industry.<sup>9</sup> Nothing in *Metropolitan Life* or any other decision of this Court suggests that the insurance saving clause was meant to save from preemption common law theories which have no application in particular to the business of insurance, but rather apply to all contracting parties generally.

Treating common law actions for benefits under ERISA plans as "laws" which "regulate insurance" would not

<sup>8</sup> For the convenience of the Court, we have lodged with the Clerk ten copies of the unpublished *Benvenuto* opinion.

<sup>9</sup> Section 514(c) of ERISA, 29 U.S.C. 1144(c), defines "state law" to include "decisions" as well as "laws," "rules," and "regulations." However, before a state law, whether statutory or decisional law, obtains the benefit of the insurance saving clause, it must qualify as a law "which regulates insurance." A complaint seeking relief under the common law of contracts, in contrast to a law applicable in particular to the business of insurance or the insurance industry, does not meet that description.

only collide with the literal language of the insurance saving clause, but also would defeat Congress' manifest purpose. As ERISA's Conference Report explained: "All such actions in Federal or State court [to recover ERISA benefits provided through insurance or otherwise] are to be regarded as arising under the laws of the United States \* \* \*." H.R. Conf. Rep. No. 93-1280, *supra*, 3 U.S. Code Cong. & Admin. News at 5107 (1974) (emphasis supplied). Construing the insurance saving clause to preserve such actions from preemption would defeat the Congressional intent to resolve "all" such actions exclusively under federal law.

**2. Common law doctrines of general applicability are not preserved by the insurance saving clause because they are not within the area reserved for state regulation under the McCarran-Ferguson Act.**

As this Court observed in *Metropolitan Life, supra*, 105 S. Ct. at 2392 n.21, ERISA's insurance saving clause "appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." Both statutes "serve the same federal policy and utilize similar language to define what is left to the States." *Ibid.* The McCarran-Ferguson Act provides in relevant part that "[t]he business of insurance \* \* \* shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012. Accordingly, it is appropriate to turn to the McCarran-Ferguson Act for confirmation of the principle that ERISA's insurance saving clause does not save from preemption general common law claims challenging the administration of an employee welfare benefit plan.

The distinction between laws of general application and laws regulating insurance has been recognized consistently

in cases construing the McCarran-Ferguson Act, which served as the model for the insurance saving clause. See, e.g., *Hart v. Orion Ins. Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971) (ruling that arbitration statutes are "laws of general application pertaining to the method of handling contract disputes" and do not regulate the business of insurance); accord, *Hamilton Life Ins. Co. v. Republic National Life Ins. Co.*, 408 F.2d 606, 611 (2d Cir. 1969) (holding that the McCarran-Ferguson Act does not preserve state laws "regulating the method of handling contract disputes generally"). Thus, the relevant cases establish that the McCarran-Ferguson Act was designed only to protect legislative and regulatory provisions focused specifically on the business of insurance.

This Court's latest decision defining the scope of the "business of insurance," reserved by Congress for state regulation under the McCarran-Ferguson Act, leaves no doubt that disputes over claims resolution, which involve persons outside of the insurance industry, are beyond the area reserved for the states. In *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 130-134 (1982), this Court, relying on several criteria for determining the scope of the McCarran-Ferguson Act, ruled that an insurance company's use of a "peer review committee" to determine the compensability of insurance claims was not a part of the "business of insurance." The Court explained that it was not enough that the practices challenged were "an aid in determining the scope of the transfer" of risk. The Court pointed out that the "transfer of risk," which is the primary focus of the McCarran-Ferguson Act, does not occur "when the insured's claim is settled," but rather when the insurance policy is sold. The Court emphasized that resolution of a dispute over "whether the insured's loss [fell] within policy limits" is

beyond the scope of the area reserved for exclusive state regulation. *Ibid.*

In addition, because the insurance practices at issue in *Pireno* included "third parties wholly outside the insurance industry," the McCarran-Ferguson Act was deemed inapplicable. The Court explained that "[a]rrangements between insurance companies and parties outside the insurance industry can hardly be said to lie at the center of [the] legislative concern." *Ibid.*

Likewise, common law complaints seeking damages for alleged improper administration of employee welfare benefit plans are far beyond the scope of the McCarran-Ferguson Act, and, by analogy, beyond the scope of the ERISA insurance saving clause as well. Such contract disputes focus only on the manner "in which the insured's claim is settled," and in no manner focus on the "transfer of risk." And they directly affect "third parties"—such as General Motors and its employee benefit plan—which are wholly "outside the insurance industry."<sup>10</sup>

**3. Preservation of state common law causes of action for alleged improper administration of an employee welfare benefit plan would clash with Congress' intent to immunize such plans from direct state regulation.**

A third fundamental objection to preserving Taylor's state law cause of action under the insurance saving clause is that this interpretation would result in a direct application of inconsistent state law principles to the administration of ERISA-covered plans. State law, not federal law, would determine the remedies of employees challenging the grant or denial of ERISA

<sup>10</sup> As explained on pages 38-39 and 46-47, *infra*, Congress has provided that neither ERISA plans nor the employers that sponsor them may be deemed to be engaged in the business of insurance.

benefits, and the rights of employees under multi-state plans would vary from state to state. That result would totally defeat Congress' goal of fair and uniform plan administration as expressed in the text of ERISA, the legislative history, and this Court's decision in *Metropolitan Life*.

Congress was well aware that litigants might argue that the insurance saving clause should be extended to preserve state laws that would apply directly to ERISA-covered employee welfare benefit plans. To guard against that result, Congress expressly provided in the "deemer" clause, Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), that an "employee benefit plan" shall not "be deemed \* \* \* to be engaged in the business of insurance" for "purposes of any law of any State purporting to regulate insurance companies" or "insurance contracts." The unmistakable import of this language is that state law may not be applied to the plan itself, notwithstanding any argument that might be made that such application constitutes "regulation" of the business of "insurance."

The Congressional intent embodied in the "deemer" clause was clearly set forth in H.R. Rep. No. 94-1785, 94th Cong., 2d Sess. 46 (1977), a Report relied on by this Court in *Metropolitan Life*, *supra*, 105 S. Ct. at 2393 n.25, as follows (emphasis supplied):

The provisions of section 514 expressly reserve to Federal authority the regulation of employee benefit plans subject to the jurisdiction of the Act. In electing deliberately to preclude state authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities. There was a recognition of the necessity for the preservation of some state activity in this field and certain limited exceptions were made to the broad preemption scheme. *In general these exemptions are designed to*

*save state law as it is applied to entities which are not employee benefit plans as defined in section 4(a) \* \* \* to the extent that regulation does not relate to employee benefit plans.*

The Report further explained that while "it was clear that the plans subject to ERISA needed to be freed of the possibility of state regulation," it was necessary to limit the scope of preemption to avoid disrupting state efforts to "regulate the conduct of other financial entities not subject to the federal Act." *Ibid.* Thus, the "deemed" language was utilized to "create an irrebuttable presumption that these plans are not insurance \* \* \* companies for purposes of state regulation." *Id.* at 47. "Accordingly, any activity by a state or political subdivision thereof, which relates to employee benefit plans, qua benefit plans, is preempted by section 514(a)." *Id.* at 48.

This Court gave effect to the foregoing legislative policies in *Metropolitan Life* when it concluded that the "deemer" clause intended to "exempt[] from the saving clause laws regulating insurance contracts that apply directly to benefit plans." 105 S. Ct. 2390. That specific limitation upon the scope of the insurance saving clause has been recognized by commentators as well. See, e.g., Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. Chicago L. Rev. 23, 66 (1978) ("Under this exception to the savings clause, it would appear that benefit plans continue to be free of direct regulation by the state even if that regulation is part of a general body of insurance law"); Kilberg and Inman, *Preemption of State Laws Relating to Employee Benefit Plans*, 62 Texas L. Rev. 1313, 1337 (1984) ("Nothing in the legislative history suggests that the purpose of

the savings clause was to preserve laws that, by reason of their dual nature, could be characterized both as employee benefit plan regulation and, for example, as insurance regulation").

Acceptance of Taylor's contrary theory that state common law principles remain available to contest the grant or denial of benefits under ERISA plans whenever such plans are partially financed by an insurance company would seriously obstruct the operation of this comprehensive and reticulated federal statute. Application of state law would not only constitute "direct" regulation of ERISA plans, but direct regulation of a most disruptive and harmful sort.

ERISA makes fiduciary conduct and plan administration a matter of exclusive federal concern. See pp. 13-15, *supra*. Unlike state contract and tort law, ERISA does not provide participants with a right to a jury trial. See, e.g., *Calamia v. Spivey*, 632 F.2d 1235, 1237 (5th Cir. 1980); *Wardle v. Central States Pension Fund*, 627 F.2d 820, 829 (7th Cir. 1980). This federal policy would be overridden by preservation of state law causes of action which challenge the administration of employee welfare benefit plans.

In addition, the standard of review under ERISA is entirely different from that under state common law. Federal courts do not conduct a hearing *de novo* on a participant's eligibility for benefits; rather, they engage in limited judicial review of the fiduciary's decision to determine whether it is "arbitrary or capricious." *Holland v. Burlington Industries*, 772 F.2d 1140, 1148 (4th Cir. 1985); *Wolf v. National Shopmen Pension Fund*, 728 F.2d 182, 187 (3d Cir. 1984); *Lawrence v. Westerhaus*, 780 F.2d 1321, 1322-1323 (8th Cir. 1985).

Moreover, Congress provided in Section 503 of ERISA, 29 U.S.C. 1133, that every employee benefit plan must provide an internal claims resolution procedure, allowing submission of claims with "full and fair review by the appropriate named fiduciary." The rules and procedures applicable under this provision apply both to insured and uninsured plans. 29 C.F.R. 2560.503-1(c) and (g)(2). In contrast to common law proceedings, courts applying ERISA require claimants to exhaust these internal claims review procedures before filing suit. See, e.g., *Kross v. Western Electric Co.*, 701 F.2d 1238, 1244-1245 (7th Cir. 1983); *Denton v. First National Bank*, 765 F.2d 1295, 1302 (5th Cir. 1985).

Finally, and most importantly, ERISA, unlike state law, restricts a participant's ability to recover punitive, exemplary, or extra-contractual damages for improper processing of benefit claims, even if the defendant is an insurance company. See *Massachusetts Mutual Life Insurance Co. v. Russell*, *supra*, 105 S. Ct. at 3091; see also *Bittner v. Sadoff & Rudoy Industries*, 728 F.2d 820, 825 (7th Cir. 1984). Retention of common law causes of action would open the door to remedies which ERISA forbids, as Taylor's complaint in this case illustrates.

In short, Congress intended the statutory provisions and policies of ERISA to apply to *all* employee benefit welfare plans, whether benefits are provided "through the purchase of insurance or otherwise." Section 3(1), 29 U.S.C. 1002(1). The most fundamental purposes of ERISA would be frustrated if participants, such as Taylor, were free to file state law claims against plan fiduciaries based on alleged improper plan administration. Thus, for good reason, the insurance saving clause does *not* preserve "laws regulating insurance contracts that apply directly to benefit plans" (*Metropolitan Life*,

*supra*, 105 S. Ct. at 2390), and it does not save Taylor's cause of action from federal preemption.

The foregoing analysis of the insurance saving clause demonstrates that the Fifth Circuit seriously erred in *Pilot Life* when it upheld a state law cause of action challenging the administration of an ERISA-covered plan. While we believe that the statutory language and legislative history are sufficiently clear to require a rejection of the *Pilot Life* rationale, common sense consideration of the practical impact of *Pilot Life* should be added to the balance. As we have shown, acceptance of *Pilot Life's* grudging approach to ERISA preemption would unravel in a single stroke a host of vitally important federal policies which Congress intended to apply to *all* ERISA-covered plans, whether insured or uninsured. This Court should not defeat the manifest purpose of Congress by construing the insurance saving clause so broadly as to eviscerate the general preemption provision—a provision which Congress deemed to be the “crowning achievement” of this remedial legislation. See p. 13, *supra*.

**B. *Pilot Life* is irrelevant to the issue of removal presented in this case.**

As we have demonstrated, *Pilot Life* seriously misconstrued ERISA's insurance saving clause. Because the saving clause does not save Taylor's complaint from federal preemption, his complaint necessarily arises under federal law and is removable to federal court. But even assuming *arguendo* that Taylor's cause of action is not preempted, it is still removable to federal court. That is true for two independent reasons. *First*, even assuming that ERISA does not preempt Taylor's claim for benefits, that would not alter the fact that his claim falls squarely within the “original jurisdiction” of the federal

district court. That is sufficient to support removal under 28 U.S.C. 1441(a) and (b). *Second*, Taylor's complaint seeks ERISA benefits that are *not* insured. His claim for uninsured salary continuation benefits is unaffected by the “insurance saving clause” and is necessarily preempted by federal law. Accordingly, Taylor's separate and independent claim for uninsured ERISA benefits is sufficient to support removal under 28 U.S.C. 1441(c).

**1. Taylor's complaint falls within the district court's original jurisdiction and therefore is removable without regard to the scope of federal preemption.**

In unambiguous terms, the federal removal statute, 28 U.S.C. 1441(a), provides that “any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendants \* \* \* to the district court.” As explained on page 13, *supra*, there is no question that Taylor's claim for “reimplementation of all benefits” under an ERISA-covered plan (Pet. App. 28a-29a) falls squarely within the “original jurisdiction” of the district court. Section 502 of ERISA expressly provides that all such claims “to recover benefits,” to “enforce rights” or to “clarify rights to future benefits” under an ERISA-covered plan may be adjudicated by the district court without regard to the amount in controversy or the citizenship of the parties.<sup>11</sup>

<sup>11</sup> ERISA's grant of jurisdiction is reinforced by 28 U.S.C. 1337(a), which confers “original jurisdiction” on the district court to entertain “any civil action or proceeding arising under any Act of Congress regulating commerce.” These broad grants of original jurisdiction are sufficient to support removal in the present case. See 1A *Moore's Federal Practice* ¶ 0.157[5] at p. 121 (1983 ed.): “the reference in Section 1441 to the original jurisdiction of the

[Footnote continued]

Congress had authority to extend the "original jurisdiction" of the district courts as far as necessary to protect the policies of ERISA. See *Verlinden B.V. v. Central Bank of Nigeria*, 461 U.S. 480, 492, 494-496 (1983); *National Mutual Ins. Co. v. Tidewater Transfer Co.*, 337 U.S. 582, 600 (1949) (plurality opinion); *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 460 (1957) (Burton and Harlan, J.J., concurring); Mishkin, *The Federal "Question" In The District Courts*, 53 Colum. L. Rev. 157, 196 (1953) ("The protective forum [made available through a statutory grant of original jurisdiction to the district courts] is then, principally, a shield for federal legislation. In a very real sense do all such cases 'arise under' the laws establishing the congressional plan").

When it conferred original jurisdiction on the district courts to adjudicate complaints such as Taylor's complaint, Congress expressly found that "ready access to the Federal courts" is essential to "protect interstate commerce." And it granted such jurisdiction as an integral part of a comprehensive program to regulate interstate commerce. ERISA Section 2(b), 29 U.S.C. 1001 (b). Accordingly, Congress' grant of original jurisdiction under ERISA is independently sufficient to support removal in this case, regardless of the resolution of the preemption issue raised in *Pilot Life*. See, e.g., *Leonardis v. Local 282 Pension Trust Fund*, *supra*, 391 F. Supp. at 557; *Buck v. Union Trustees Pension Fund*, *supra*, 70 F.R.D. at 531; *McConnell v. Marine Engineers Beneficial Ass'n*, *supra*, 526 F. Supp. at 771-773 (permitting removal of an ERISA benefit case and noting that "[b]y

district courts is not limited to the original jurisdictional grants contained in Section 1331 and 1332; the reference is as broad as the district courts' original jurisdiction." See also *Avco*, *supra*, 390 U.S. at 561-562.

enacting the removal statute, Congress has granted defendants a right to have any action coming under the original jurisdiction of the district courts tried in those courts unless the legislature makes an *express* determination that such removal is unwarranted. Such a determination was not made in this case").<sup>12</sup>

In short, the literal language of ERISA and the federal removal statute suffice to show that Taylor's complaint falls within the original jurisdiction of the district court and is removable from state court. Moreover, as discussed on pages 29-30, *supra*, the relevant legislative history shows that Congress *intended* cases such as this to be removable. Thus, to deny removal here would require the Court to disregard not only the literal language used by Congress, but also its manifest intent to provide ready access to the federal courts in ERISA benefit cases. See *Board of Governors v. Dimension Financial Corp.*, — U.S. —, 106 S.Ct. 681, 689 n.7 (1985) (federal legislation must be construed "as Congress ha[s] written it").

<sup>12</sup> Taylor's complaint not only falls within the "original jurisdiction" of the district court, but also necessarily raises substantial federal law issues regardless of the scope of federal preemption. This is so because Taylor seeks benefits under an employee benefit plan established under federal law, and because his rights are defined by reference to the plan and the matrix of federal regulations which surrounds it. His very standing to bring suit for ERISA benefits depends on his proof that he is a plan participant as defined by federal law. See *Allis-Chalmers Corp. v. Lueck*, *supra*, 105 S. Ct. 1914-1915 ("Since the extent of \* \* \* duty ultimately depends upon the terms of the agreement between the parties, \* \* \* [it is] tightly bound with questions of contract interpretation that must be left to federal law"). See also *Oneida Indian Nation v. County of Oneida*, 414 U.S. 661, 677-678 (1974); *Hopkins v. Walker*, 244 U.S. 486, 489-491 (1917). This federal law element confirms the propriety of removal under 28 U.S.C. 1441(a) and (b), as explained in more detail in the brief for petitioner filed in this Court in *Merrill Dow Pharmaceuticals v. Thompson*, No. 85-619, at 12-14, 22-49.

**2. Taylor's complaint contains a separate and independent claim for uninsured salary continuation benefits which is governed by federal law and which supports removal of his entire complaint.**

There is an additional reason why Taylor's complaint is removable to federal court even assuming *arguendo* that *Pilot Life* correctly held that claims for "insured" benefits are saved from federal preemption by ERISA's insurance saving clause. The insurance saving clause saves from preemption "any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Taylor's complaint in this case, however, contains a separate claim for "salary continuation" benefits (see Pet. App. 27a-28a) which are *uninsured*. That claim plainly falls outside of the insurance saving clause and is accordingly subject to ERISA's preemption provision.

There can be no serious dispute about the status of the General Motors Salary Continuation Benefits sought by Taylor's complaint. Those benefits are financed by General Motors from its own current revenues. They are not insured, directly or indirectly, and neither Metropolitan Life nor any other insurance company is responsible for providing them. See pp. 2-3, *supra*.<sup>13</sup> A state law cause of action seeking such uninsured benefits from General Motors is plainly beyond the scope of the insurance saving clause. See *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423 (4th Cir. 1985), holding that an employer "cannot be deemed to be

<sup>13</sup> As explained on pp. 2-3, *supra*, and in the summary plan description, J.A. 111, 117, the uninsured salary continuation benefits sought by Taylor are part of General Motors' ERISA-covered Insurance Program and they are designed to supplement sickness and accident benefits. The program also provides extended disability benefits for longer service employees and total and permanent disability benefits for eligible employees with less than ten years of service. See J.A. 114, 118.

an insurer or otherwise engaged in the business of insurance by virtue of its sponsorship of the Plan, and [the employee's] claims against [the employer] under state law regulating insurance are not exempted from preemption, by the insurance saving clause." See also *Moore v. Provident Life and Accident Insurance Company, et al.*, — F.2d —, Nos. 85-1887, 85-1957 (9th Cir. April 7, 1986).

As this Court was at pains to point out in *Metropolitan Life, supra*, 105 S. Ct. at 2393, "uninsured" employee benefits are not open to even "indirect regulation" under state law. ERISA's preemption provision protects uninsured ERISA benefit programs from the application of any state law. *Id.* at 2389. See also *Children's Hospital v. Whitcomb*, 778 F.2d 239, 241-242 (5th Cir. 1985); *Kilmer v. Central Counties Bank*, 623 F. Supp. 994, 1000-1002 (W.D. Pa. 1985); *Cuttle v. Federal Employees Council*, 623 F. Supp. 1154, 1157 (D. Me. 1985).

Because Taylor's complaint contains a separate claim for uninsured benefits from General Motors which is governed solely by federal law, his entire complaint is removable to federal court under 28 U.S.C. 1441(c), which provides that "[w]henver a separate and independent claim or cause of action, which would be removable if sued upon alone, is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed \* \* \*." See *Franchise Tax Board, supra*, 463 U.S. at 13, noting, with reference to ERISA, that "if either [claim] comes within the original jurisdiction of the federal courts, removal was proper as to the whole case."

In sum, it is irrelevant to the outcome of this case whether *Pilot Life* correctly construed ERISA's insurance saving clause to preserve state law causes of action seek-

ing "insured" ERISA benefits. The present case is clearly removable to federal court because it falls within the "original jurisdiction" of the district court, and because it contains a "separate and independent claim" for uninsured salary continuation benefits which supports removal of the entire case. Under the literal language used by Congress in ERISA and the federal removal statute, either of these grounds is independently sufficient to support removal of Taylor's complaint.

### CONCLUSION

The decision of the court of appeals should be reversed.

Respectfully submitted.

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## APPENDIX

### RELEVANT STATUTORY PROVISIONS

1. Section 2 of ERISA, 29 U.S.C. 1001, provides in relevant part:

(a) The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; [and] that they are affected with a national public interest  
\* \* \*

(b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

2. Section 3 of ERISA, 29 U.S.C. 1002, provides in relevant part:

For purposes of this subchapter: (1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was

established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment \* \* \*.

3. Section 502 of ERISA, 29 U.S.C. 1132, provides in relevant part:

(a) A civil action may be brought—

(1) by a participant or beneficiary—

\* \* \*

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan \* \* \*.

\* \* \*

(e) (1) \* \* \* State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions brought under subsection (a) (1) (B) of this section.

(f) The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

4. Section 514 of ERISA, 29 U.S.C. 1144, provides in relevant part:

(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and

all State laws insofar as they may now or hereafter relate to any employee benefit plan \* \* \*.

\* \* \*

(b) (2) (A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

\* \* \*

(b) (2) (B) Neither an employee benefit plan \* \* \* nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

\* \* \*

(c) For purposes of this section: (1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. \* \* \* (2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

5. The federal removal statute, 28 U.S.C. 1441, provides in relevant part:

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of which the district courts of the United

{ States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

(c) Whenever a separate and independent claim or cause of action, which would be removable if sued upon alone, is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters not otherwise within its original jurisdiction.

# **RESPONDENT'S BRIEF**

Nos. 85-686 and 85-688

Supreme Court, U.S.

FILED

JUL 1 1985

JOSEPH P. GRANIOL, JR.  
CLERK

IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1985

GENERAL MOTORS CORPORATION and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioners,*

v.

ARTHUR TAYLOR,  
*Respondent.*

On Writs of Certiorari to the United States  
Court of Appeals for the Sixth Circuit

**BRIEF FOR RESPONDENT**

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## **QUESTIONS PRESENTED**

1. Whether a lawsuit alleging multiple claims based exclusively on state law properly may be removed under 28 U.S.C. § 1441 where plaintiff's complaint is well-pleaded, but the district court determines, in the face of conflicting authority and substantial arguments to the contrary, that one of the state law claims is preempted by federal law and supplanted by a federal cause of action.

2. Whether the Employee Retirement Income Security Act of 1974 (ERISA) preempts a breach of contract claim against an insurance company where ERISA exempts from preemption state regulation of insurance, including regulation effected through the traditional mechanism of common law actions by insureds against their insurers.

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1985

Nos. 85-686 and 85-688

GENERAL MOTORS CORPORATION and  
 METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioners,*  
 v.  
 ARTHUR TAYLOR,  
*Respondent.*

On Writs of Certiorari to the United States  
 Court of Appeals for the Sixth Circuit

## BRIEF FOR RESPONDENT

## STATEMENT

Respondent Arthur Taylor was employed by petitioner General Motors for nearly thirty years, as an hourly worker from 1951 to 1959, and as a salaried employee from 1959 to 1980. In 1961, respondent received a job-related back injury for which he filed a worker's compensation claim. Although prior to this claim respondent had been promoted on several occasions, all subsequent requests for promotions and transfers were denied. GM Pet. App. 12a-13a. In May 1980, respondent took a leave of absence due to emotional problems arising from a protracted divorce and custody dispute. A psychological examination confirmed that respondent was suffering from a psychiatric disorder, and he was also referred for treatment of his back ailment. GM Pet. App. 2a.

Respondent Metropolitan Life Insurance Company, General Motors' insurance carrier, initially paid respond-

ent disability benefits. On the basis of subsequent medical examinations, however, Metropolitan Life changed its mind, concluding that neither respondent's psychiatric nor orthopedic problems qualified him as "disabled" under the insurance policy. General Motors agreed with this determination following a further examination of respondent by its own doctors. Disability payments to respondent were terminated at the end of July 1980. When respondent subsequently failed to return to work because of his medical condition, he was fired by General Motors. GM Pet. App. 2a-3a.

On March 13, 1981, respondent filed suit against petitioners in the Circuit Court for Wayne County, Michigan. GM Pet. App. 11a. His complaint contained two counts. J.A. 19-24. The first count, directed at General Motors exclusively, asserted a claim of wrongful discharge. Specifically, respondent alleged that he had been fired in retaliation for the filing of the worker's compensation claim, and because of medical restrictions that limited his work activities. J.A. 21. The second count stated a claim for breach of the insurance contract between respondent and Metropolitan Life. J.A. 22-24. This count described various benefits to which respondent was entitled under the contract, including health coverage and two types of disability benefits, and alleged that "Metropolitan Life Insurance Company wrongfully and maliciously discontinued said insurance coverage in breach of the insurance contract." J.A. 23. Respondent sought payment of past due benefits, compensation for mental anguish caused by the termination of coverage, and "reimplementation of all benefits and insurance coverages Plaintiff is entitled to." J.A. 23-24. Just as the first count of the complaint was directed to General Motors exclusively, the contract claim of the second count was directed exclusively to Metropolitan Life.<sup>1</sup>

<sup>1</sup> As discussed later, pages 47-48, *infra*, a fair reading of respondent's original and amended complaints makes clear that he sought recovery for breach of the insurance contract only against Metropolitan Life, not General Motors.

On March 24, petitioners jointly moved for removal of the case to the United States District Court for the Eastern District of Michigan. GM Pet. App. 30a. Petitioners claimed that respondent's contract claim for breach of the insurance policy, although cast as a state law cause of action, was in actuality a federal claim under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. Petitioners contended that this contract claim was both preempted by ERISA and replaced with an ERISA cause of action. GM Pet. App. 31a. The district court agreed with petitioners, denying respondent's motion to remand the lawsuit to state court. GM Pet. App. 9a. After granting respondent leave to amend his complaint,<sup>2</sup> the district court proceeded to decide respondent's purely state law claims (for wrongful discharge and breach of the employment contract) and assertedly federal claim (for breach of the insurance policy) on the merits. On May 17, 1984, the court granted summary judgment in favor of petitioners. GM Pet. App. 10a-19a.

On appeal the Court of Appeals for the Sixth Circuit reversed. GM Pet. App. 1a. After noting a split in authority on the question whether a state law contract claim like respondent's may be federalized by ERISA, GM Pet. App. 4a-5a, the court concluded that respondent's well-pleaded complaint alleged only state law claims and therefore afforded no basis for removal jurisdiction under 28 U.S.C. § 1441. Relying on this Court's decision in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), the Court of Appeals held that respondent's invocation of state law should be respected because he had not sought to avoid federal jurisdiction by "artful" pleading. GM Pet. App. 6a. While acknowledging that certain state law claims involving labor disputes

<sup>2</sup> Respondent's amended complaint was virtually identical to the original complaint, with the exception of the addition of a third count against General Motors alleging breach of respondent's employment contract. J.A. 233-39.

may be transformed on removal into federal claims, GM Pet. App. 8a, the well-pleaded complaint doctrine was found to preclude removal of respondent's case because it was not "clearly established" that his contract claim under the insurance policy was both preempted by ERISA and replaced with an ERISA cause of action. GM Pet. App. 7a. The court thus refrained from reaching the merits of petitioners' preemption/replacement argument.

### SUMMARY OF ARGUMENT

I. The court below held that respondent's lawsuit was not removable on the basis of the district court's determination that the insurance contract claim was, in actuality, a federal cause of action. A century of Supreme Court removal jurisprudence stands four-square in support of that conclusion. The centerpiece of that jurisprudence is the well-pleaded complaint doctrine, animated by the principle that a plaintiff is "the master of his case" and, therefore, may guarantee a state court forum by alleging in good faith only state claims and forgoing alternative federal claims that might be available to him.

A. The only relevant limitation on this principle is that a plaintiff may not avoid federal jurisdiction where it is *obvious* from the outset of the litigation that his claims can only be federal. The "obviousness" test is an aspect of the broader rule that, when presented with a petition for removal, a district court may question a plaintiff's reliance on state law only where that reliance constitutes "fraud" or "artful pleading." See *Great Northern Ry. v. Alexander*, 246 U.S. 276 (1918). But this limitation has absolutely no applicability where, as here, a plaintiff asserts claims predicated exclusively on state law; the invocation of state law is made in good faith; and, in view of conflicting precedent, the alleged federal nature of one of these claims is anything but obvious.

The obviousness standard properly limits the scope of removal jurisdiction for three reasons. First, allow-

ing removal where it is not obvious that plaintiff's claim exists only under federal law cannot be squared with plaintiff's right to choose his forum. The choice of a state court may often play a significant role in a plaintiff's decision to litigate. If the right to choose one's forum means anything, a plaintiff should not have to bear the risk of being hauled into federal court simply because he has failed to accurately predict how that court would resolve a difficult question of federal preemption. Indeed, abandonment of the obviousness standard would cause plaintiffs to refrain from raising perfectly valid state law claims in order to insure that their state court forum choice will be respected.

Second, departure from the obviousness test creates unnecessary state-federal conflicts. If it is not obvious that a plaintiff's state law claim is both preempted and governed by federal law, the district court must base its jurisdictional determination on an unsettled question of statutory interpretation. Should the court reject the defendant's preemption claim and remand the case to state court, the *res judicata* effect of that decision effectively usurps the authority of the state court to resolve the preemption issue. This result flies in the face of the long-recognized principle that the federal courts are courts of limited jurisdiction and state courts are competent to determine whether state laws may stand in the face of federal regulation.

Third, by reducing the risk of improper removal, the obviousness limitation also protects plaintiffs from the substantial burden of having to litigate their claims twice. Consider what can happen if the limitation is not applied: a plaintiff files suit in state court alleging multiple state claims, one of which is arguably—and only arguably—preempted by a federal claim that provides an alternative remedy. The district court then proceeds to final judgment on the putative federal claim, as well as the pendant state law claims. If it is later determined

on appeal that removal was improper, the entire litigation has been for naught, and the plaintiff is compelled to start from scratch in the forum that he originally selected. The resulting hardship and waste of judicial resources describes precisely what has transpired in this case.

B. Petitioners' attempt to create a new exception to the well-pleaded complaint doctrine, permitting removal in the absence of obviousness or other indicia of fraud or artful pleading, should be rejected. Petitioners rely primarily on *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), which involved the removal of an employer's state law claim to enforce a collective bargaining agreement. However, central to the Court's decision sustaining removal in that situation was the fact that prior decisions established unequivocally that the plaintiff's claim could only be federal. Petitioners ignore the already-settled nature of the preemption issue presented in *Avco*. Far from supporting a departure from the obviousness test, *Avco* stands as an example of that test.

That *Avco* does not authorize removal where it is only possible that a state law claim is preempted is confirmed by the Court's later decision in *Franchise Tax Board v. Construction Laborers Vacation Trust, supra*, 463 U.S. at 22, characterizing *Avco* as a "corollary" of the well-pleaded complaint doctrine—not a major exception to it. Moreover, petitioners' proposed rule, requiring a district court to determine, first, whether a plaintiff's state law claim is preempted and, second, whether the preemptive law creates a substitute federal claim, flies in the face of the long-settled principle that a federal defense—including the defense of preemption—affords no basis for removal. See *Gully v. First National Bank*, 299 U.S. 109 (1936). Despite petitioners' arguments to the contrary, the first step in their proposed analysis necessarily requires the court not only to consider a federal defense, but to decide the defense on the merits.

II. Even if the court below erred in its application of removal principles, the decision must nonetheless be affirmed because respondent's contract claim for breach of his insurance policy was not preempted by ERISA, much less replaced by an alternative federal claim. Respondent's state law claim is exempted from ERISA preemption by the statute's "savings clause" for state regulation of insurance, as interpreted by this Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985). Here, as in *Metropolitan Life*, state substantive law relating to insurance has been invoked to compel an insurer to pay benefits that it does not wish to pay. The breadth of the insurance savings clause, preserving even state regulation in areas that are also regulated by ERISA, is fully adequate to save insurance contract claims like respondent's.

A. There is no basis in the law or common sense for petitioners' asserted distinction under the savings clause between state statutes and administrative regulations focused explicitly on insurance—which petitioners concede are not preempted—and contract and related common law actions by insureds—which, in petitioners' view, are preempted. The distinction is precluded by the plain meaning of ERISA's statutory language, which defines the range of state regulation preserved by the savings clause to include not only legislative enactments but also judicial "decisions"—a term consistently interpreted by the lower federal courts as meaning common law claims sounding in tort and contract. And there is no question that such private litigation "regulates" insurance within the meaning of ERISA.

The factual predicate for petitioners' proposed distinction is also lacking. Contrary to their conclusory assertions, common law actions against insurers are not garden variety contract claims involving principles of "general applicability." Such claims are litigated against a backdrop of statutory policies and are governed by spe-

cialized doctrines of contract interpretation that are peculiar to the insurance industry and regulate the relationship between policyholders and insurers far more closely than the relationship between other contracting parties. And even if such specialized doctrines do not apply in every lawsuit against an insurer, any rule of ERISA preemption that attempted to distinguish between those that do, and those that do not, would pose impossible line-drawing problems—particularly at the removal stage, where this overly fine distinction would have to be made in the absence of a factual record.

B. Petitioners' second line of attack is that insurance contract claims like respondent's would thwart Congress' intention to subject ERISA plans to a uniform body of federal regulation. The short answer to this contention is that precisely the same argument was rejected in *Metropolitan Life*, where the extent of alleged interference with the federal scheme was, if anything, far greater. Petitioners also attempt to bolster this recycled argument with the claim that section 502 of ERISA, 29 U.S.C. § 1132, which creates federal remedies in part modeled on section 301 of the Labor Management Relations Act (LMRA), 29 U.S.C. § 185, has its own preemptive effect, independent of ERISA's basic preemption provision.

The argument is misconceived. The references to section 301 in ERISA's legislative history mean only that if a case is brought under section 502, that federal claim will be governed by federal common law. And, although section 301 has been construed as having preemptive effect, that is because the LMRA contains no preemption provision. ERISA, by contrast, provides expressly for federal preemption with a degree of detail and precision that is virtually unique in federal legislation. Because Congress has itself marked out the sphere of federal preemption, no other provision of ERISA, including section 502, can be read as expanding that sphere.

C. Nor is there any merit to petitioners' contention that respondent's breach of contract claim does not regulate the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. McCarran-Ferguson principles were found to support the decision in *Metropolitan Life*, but the Court did not hold that McCarran-Ferguson's protection of state law was coextensive with ERISA's savings clause. Even if McCarran-Ferguson is relevant, however, the Act counsels against preemption here, not for it. The McCarran-Ferguson criteria for defining the "business of insurance" cited in *Metropolitan Life* are addressed primarily to economic arrangements that are ancillary to insurance; respondent's case, by contrast, is at the core of the business of insurance because it concerns the interpretation and effect to be given an insurance policy. In any case, the McCarran-Ferguson criteria are fully satisfied by the substantive law of insurance contracts invoked by respondent.

D. Finally, petitioners advance the argument that, even if most of the insurance benefits covered by respondent's contract claim are saved from preemption, a claim for coverage under a "Salary Continuation Benefit" is uninsured and therefore not subject to ERISA's savings clause. This claim, however, disregards the fact that, under applicable Department of Labor regulations, this particular benefit is not governed by ERISA at all and, for that reason, falls outside the scope of ERISA's basic preemption provision. And even if this were not the case, the argument fails for the separate reason that respondent's claim for salary continuation benefits was directed at Metropolitan Life exclusively. Thus, whether or not Metropolitan Life had any authority to grant or deny the requested coverage, respondent's claim in this regard sought recovery only from an insurance carrier and, for that reason, is subject to the ERISA savings clause.

## ARGUMENT

### I. THE COURT OF APPEALS CORRECTLY HELD THAT RESPONDENT'S CHOICE OF A STATE COURT FORUM FOR THE ADJUDICATION OF STATE LAW CLAIMS COULD NOT BE DEFEATED BY PETITIONERS' QUESTIONABLE ASSERTION THAT ONE OF THOSE CLAIMS WAS PREEMPTED BY FEDERAL LAW AND SUPPLANTED BY A FEDERAL CAUSE OF ACTION.

The Court of Appeals below concluded that the district court was without power to look behind respondent's reliance on state law and, on the basis of a preemption defense, to transform his state claim for breach of an insurance contract into a federal claim under ERISA. The district court's removal jurisdiction did not reach so far, the Court of Appeals reasoned, because respondent had asserted a colorable state law claim—one that was not *obviously* federal in nature. Despite petitioners' argument that respondent's contract claim was both preempted by ERISA and supplanted by an ERISA cause of action, the Court of Appeals found that removal was improper because petitioners' position on these matters was not "clearly established." G.M. Pet. App. 7a.

In so holding, the Court below correctly applied the well-pleaded complaint doctrine, which has been long-recognized as defining the scope of a federal district court's removal jurisdiction. Under that doctrine a plaintiff's invocation of state law will be respected, and his lawsuit treated as nonremovable, unless it can be shown that he has avoided stating a federal claim by "fraud" or "artful pleading." Absent evidence of such a fraudulent attempt to defeat federal jurisdiction, there is simply no basis for a district court, on a defendant's petition for removal, to question a plaintiff's reliance on state law. Petitioners now urge this Court to significantly expand removal jurisdiction by permitting removal even where

the assertedly preemptive effect of federal law is an open and unsettled question. The argument is contrary to precedent and common sense.

### A. Because Respondent's Insurance Contract Claim Was Not Obviously Federal, Removal Was Improper.

The federal removal statute, 28 U.S.C. § 1441(a), provides in relevant part that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending." In nondiversity cases, where jurisdiction turns on the presence of a federal question, the inquiry focuses on whether the case is one "arising under the Constitution, treaties or laws of the United States." 28 U.S.C. § 1441(b). While the test for determining "arising under" jurisdiction is not self-evident, see *Franchise Tax Board v. Construction Laborers Vacation Trust*, *supra*, 463 U.S. at 8, "[o]ne powerful doctrine has emerged" in the removal context—the well-pleaded complaint rule, *id.* at 9.

As the rule's name suggests, a case does not arise under federal law unless such law appears on the face of the plaintiff's well-pleaded complaint. This standard, animated by the principle that a plaintiff is "master of his case," gives effect to a plaintiff's express reliance on a given source of law, *Franchise Tax Board*, *supra*, 463 U.S. at 9-10; *Pan American Petroleum Corp. v. Superior Court*, 366 U.S. 656, 662 (1961); *Taylor v. Anderson*, 234 U.S. 74, 76 (1914), but also contemplates that, in limited circumstances, a district court may properly scrutinize the allegations in a complaint to determine whether a plaintiff's reliance on state law is, in fact, well-pleaded. It is the scope of this authority to question a plaintiff's

invocation of state law that is at issue here. We submit that respondent's reliance exclusively on state law should have been respected—and his complaint therefore regarded as well-pleaded—because, at the time of removal, it was not obvious that his claim under the insurance contract could only be stated under federal law.<sup>3</sup>

The district courts' lack of authority to look behind a plaintiff's reliance on state law is dictated by the well-established rule that such reliance can only be questioned where he has attempted to defeat federal jurisdiction by fraudulent means. *Great Northern Ry. v. Alexander*, *supra*, 246 U.S. at 281-82. Various referred to as the "fraud" or "artful pleading" exception, this aspect of the well-pleaded complaint doctrine applies in essentially two situations. One is where a plaintiff proceeds in bad faith—for example, by filing a state law claim in state court in order to relitigate a virtually identical federal lawsuit that the plaintiff previously lost in federal court. See *Federated Department Stores, Inc. v. Moitie*, 452 U.S. 394, 397 n.2 (1981). The other is where a plaintiff brings a state law claim which, on the basis of prior controlling precedent, is *obviously* a federal claim at the time the lawsuit is filed. See *Avco Corp. v. Aero Lodge No. 735*, *supra*, 390 U.S. at 560; *Lambert Run Coal Co. v. Baltimore & O R.R.*, 258 U.S. 377, 383 (1922); *Great Northern Ry.*, *supra*, 246 U.S. at 281-82. In short, raising a claim that obviously can be raised only under

<sup>3</sup> In an apparent effort to fit within the "obviousness" test, petitioners argue that one of the benefits sought in respondent's breach of contract claim—the so-called "Salary Continuation Benefit"—was "plainly" preempted and superseded by federal law, even if the other aspects of the insurance claim were not. Pet. Br. at 46-48. As we show in the second section of this brief, however, the portion of respondent's contract claim relating to this particular benefit is not preempted by ERISA. See pages 45-48, *infra*.

federal law falls within the fraud exception. Raising a colorable state law claim does not.<sup>4</sup>

This limitation on the scope of removal jurisdiction is further illustrated by cases involving "fraudulent joinder" to defeat diversity jurisdiction. The Court has long held in the diversity context that a plaintiff has the choice of structuring his suit to avoid removal by joining non-diverse defendants. See *Mecom v. Fitzsimmons Drilling Co.*, 284 U.S. 183, 189 (1931). Nevertheless, such joinder fails to prevent removal if the diverse defendant shows, *inter alia*, that it is obvious that plaintiff cannot state a cause of action against the nondiverse defendant. The obviousness standard was explained in *Chicago, R.I. & P. Ry. v. Schwyhart*, 227 U.S. 184 (1913), a case involving an action against a railroad company and one of its agents. The company argued that the plaintiff could not state a claim under state law against the agent, the non-diverse defendant. Justice Holmes, writing for a unanimous Court, held that "[o]n the question of removal we have not to consider more than whether there was a real intention to get a joint judgment, and whether there was a colorable ground for" such a judgment. *Id.* at 194; accord *Wilson v. Republic Iron & Steel Co.*, 257 U.S. 92, 97 (1921) ("[i]f . . . a resident defendant is joined, the joinder, although fair on its face, may be shown by a petition for removal to be only a sham or a fraudulent device to prevent removal").

The Court went on to stress that, in assessing the validity of plaintiff's claim against the nondiverse defendant, a district court is not only to assume the truthfulness of the plaintiff's factual allegations, but is also to refrain from an analysis of the merits of the plaintiff's legal claim. *Schwyhart*, *supra*, 227 U.S. at 194. A fed-

<sup>4</sup> We use the terms "colorable" and "obvious" similarly in the sense that a colorable state law claim is one that, by definition, is not obviously preempted by federal law and replaced with a federal cause of action.

eral district court, in other words, must remand a case to state court if there is *any chance* that the state court could find that the plaintiff has made a valid claim against the nondiverse defendant. Consistent with this principle, recent court of appeals decisions have directed the remand to state court of diversity actions where it was not obvious that the plaintiff was unable to assert a cause of action against a nondiverse defendant.<sup>5</sup>

The most important authority for present purposes is this Court's decision in *Avco Corp. v. Aero Lodge No. 735*, *supra*. In *Avco* an employer brought a contract claim in state court to enforce a "no-strike" clause in a collective bargaining agreement. The case was removed to federal court on grounds that, although cast as a state law contract action, the entire suit was preempted by section 301 of the Labor Management Relations Act, 29 U.S.C. § 185, which afforded the employer a separate federal cause of action. This Court affirmed. Central to the Court's reasoning, however, was the fact that the preemption question had been definitively resolved by prior Supreme Court decisions. The analysis of the propriety of removal in *Avco* began and ended with citations to *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448 (1947), and other cases<sup>6</sup> squarely holding that contract disputes over the interpretation and enforcement of collective bargaining agreements were governed solely by federal law under section 301. *Avco*, *supra*, 390 U.S. at

<sup>5</sup> See, e.g., *Abels v. State Farm Fire & Casualty Co.*, 770 F.2d 26, 32 (3d Cir. 1985); *Coker v. Amoco Oil Co.*, 709 F.2d 1433, 1440-41 (11th Cir. 1983); *B., Inc. v. Miller Brewing Co.*, 663 F.2d 545, 550-51 (5th Cir. Unit A 1981); *Bobby Jones Garden Apartments, Inc. v. Suleski*, 391 F.2d 172 (5th Cir. 1968).

<sup>6</sup> *Local 174, Teamsters v. Lucas Flour Co.*, 369 U.S. 95 (1962) (confirming *Lincoln Mills*' holding that § 301 preempts state damages action for violation of a no-strike clause in a collective bargaining agreement); *Humphrey v. Moore*, 375 U.S. 335 (1964) (holding that § 301 covers any contract claim based on the terms of a collective bargaining agreement).

559-60. On this basis the Court concluded that it was "clear" that the employer's claim was "one arising under the 'laws of the United States' within the meaning of the removal statute." *Id.* at 560. The employer's reliance on state law thus fell within the fraud exception because, despite the wording of the complaint, his claim was *obviously* federal.

This obviousness standard properly limits the federal courts' removal jurisdiction for several reasons. To begin with, the touchstone of the well-pleaded complaint doctrine is the principle that a plaintiff has the power to choose what claims to pursue. See *Franchise Tax Board*, *supra*, 463 U.S. at 22, quoting *The Fair v. Kohler Dye & Specialty Co.*, 228 U.S. 22, 25 (1913); *Pan American Petroleum Corp. v. Superior Court*, *supra*, 366 U.S. at 662; cf. *United States v. Mottaz*, 54 U.S.L.W. 4641, 4644 (U.S. June 11, 1986), quoting *Healy v. Sea Gull Specialty Co.*, 237 U.S. 479, 480 (1910) (noting in a case involving original jurisdiction that "the plaintiff is absolute master of what jurisdiction he will appeal to"). This Court has repeatedly made clear that if a plaintiff could state both a federal and a state claim, he is free to assert only the state claim and forgo the federal one. See, e.g., *Pan American Petroleum Corp. v. Superior Court*, *supra*, 366 U.S. at 663; *Great Northern Ry.*, *supra*, 246 U.S. at 281-82; see also 1A J. Moore & B. Ringle, *Moore's Federal Practice* ¶ 0.160[3.-3], at 230 (1985). It is only when the plaintiff elects to state a federal claim that he opens himself up to removal from state court. Thus, the plaintiff has the power to stay in state court by choosing not to raise federal claims that may be available to him.<sup>7</sup>

The choice of a state forum may often play a significant role in a plaintiff's decision to litigate. For example, the state court may be more convenient because of its

<sup>7</sup> A plaintiff is given a similar power to select his forum in the diversity context, as illustrated in the "fraudulent joinder" cases discussed earlier, pages 13-14, *supra*. See *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 294 (1938).

location; it may have a less crowded docket than the alternative federal forum; discovery in the state court may be more freely available in view of restrictions imposed by the local rules of many federal courts; and the state court may be more familiar to plaintiff's counsel—often a key consideration in deciding where to sue. Most important, one of plaintiff's claims may seek a change or extension in state substantive law. Only a state court is competent to conclusively alter state law in this way.<sup>8</sup> If plaintiff's entire case is removed to federal court on the basis that another cause of action arises under federal law, he is effectively forced to abandon this potentially promising state law claim, and the state courts are denied the opportunity to rule on plaintiff's untested theory of state law.<sup>9</sup>

Allowing removal where it is not obvious that plaintiff's claim exists only under federal law cannot be squared with plaintiff's right to choose his forum. If that choice means anything, plaintiff should not have to bear the risk of being hauled into federal court simply because he has failed to accurately predict how that court will resolve a difficult and unsettled question of

<sup>8</sup> While a district court sits as a state court when deciding questions of state law, see, e.g., *Bernhardt v. Polygraphic Co.*, 350 U.S. 198, 204-05 (1956); *Meredith v. City of Winter Haven*, 320 U.S. 228, 237 (1943), the federal court does not have the same power to change state law that a state court has, see *id.* at 234. A decision by the highest state court must be followed by all levels of the federal courts, and decisions by lower state courts must be followed unless there is a strong indication that the highest state court would decide otherwise. See *Commissioner v. Estate of Bosch*, 387 U.S. 456, 465 (1967). In any case, only an appeal to a state's highest court—obviously precluded in the event a case is removed—affords a plaintiff the opportunity to urge the modification of a prior decision of that court.

<sup>9</sup> Conversely, federal court adjudication of the state law claim is a highly inefficient use of judicial resources since the court's decision resolves only the dispute between the parties before it, and may be freely disregarded by state courts at all levels of the state judiciary.

federal preemption—particularly where, as here, the suit involves multiple state law claims, only one of which is said to be preempted. Any other rule would cause plaintiffs to refrain from raising perfectly valid state law claims in order to insure that their forum choice will not be overridden on the basis of a federal defense. Knowing that one of his state law claims potentially poses an unresolved preemption issue, a plaintiff may decide not to assert the claim in his complaint, although later decisions clearly establish that the claim was not, in fact, preempted.<sup>10</sup>

An additional justification for the obviousness standard is that any broader test creates unnecessary state-federal conflicts. If it is not obvious that a plaintiff's state law claim is preempted, the federal court must base its jurisdictional determination on its assessment of an unsettled and difficult question of statutory interpretation. See, e.g., *Lessard v. Metropolitan Life Insurance Co.*, 618 F. Supp. 1268 (D. Me. 1985). Should the court reject the defendant's preemption claim and remand the case to state court, the question immediately arises whether the state court is bound by the district court's ruling. If the state court is not bound, the plaintiff is subjected to the unnecessary burden of relitigating the preemption defense. If, on the other hand, the matter is *res judicata*, the district court has effectively usurped the

<sup>10</sup> Indeed, a plaintiff may refrain from asserting a valid state law claim even in circumstances where he has anticipated a preemption defense and is confident that it would be resolved in his favor. This is so because well-heeled defendants may assert the defense simply to put the plaintiff to the unnecessary burden of contesting the claim in federal court. The defendant stands nothing to lose from asserting a weak preemption defense on removal, although he might well forgo the same defense in the state forum selected by the plaintiff so as not to antagonize the court that will adjudicate the merits of the suit.

authority of the state court to resolve the preemption question.<sup>11</sup>

This result flies in the face of the long-recognized principle that the federal courts are courts of limited jurisdiction and that our federal system contemplates that state courts are competent to assess fairly whether state laws can stand in the face of federal regulation in a given area. See *Pan American Petroleum Corp. v. Superior Court*, *supra*, 366 U.S. at 663-65. In finding removal jurisdiction lacking in *Shamrock Oil & Gas Corp. v. Sheets*, 313 U.S. 100, 109 (1941), quoting *Healy v. Ratta*, 292 U.S. 263, 270 (1934), Justice Stone concluded, "Due regard for the rightful independence of state governments, which should actuate federal courts, requires that they scrupulously confine their own jurisdiction to the precise limits which the [removal] statute has defined."

Finally, the obviousness standard, by reducing the risk of improper removal, protects plaintiffs from the substantial unfairness of having to litigate their claims twice—first in federal court after removal, and again in state court after remand. It is for this reason that section 1441 is to be interpreted narrowly, *see, e.g., Shamrock Oil, supra*, 313 U.S. at 108; *People v. Kerr-McGee Chemical Corp.*, 677 F.2d 571, 576 (7th Cir.), *cert. denied*, 459 U.S. 1049 (1982); *Libhart v. Santa Monica Dairy Co.*, 592 F.2d 1062, 1064 (1979); that the defendant bears the burden of establishing removal jurisdiction, *see, e.g., Wilson v. Republic Iron & Steel Co.*, 257 U.S. 92, 97 (1921); *Carpenters Southern California Administrative*

<sup>11</sup> While this Court has never addressed the issue, it would appear that the decision would be binding on the state court on remand in light of the principle that the federal courts have jurisdiction to decide their jurisdiction. *See, e.g., American Surety Co. v. Baldwin*, 287 U.S. 156, 166 (1932); *Dozier v. Ford Motor Co.*, 702 F.2d 1189, 1191 (D.C. Cir. 1983). Moreover, a lack of *res judicata* effect raises the problem that the district court has issued an advisory opinion. *See, e.g., Postum Cereal Co. v. California Fig Nut Co.*, 272 U.S. 693 (1927).

*Corp. v. Majestic Housing*, 743 F.2d 1341, 1343-44 (9th Cir. 1984); *Bor-Son Building Corp. v. Heller*, 572 F.2d 174, 181 n.13 (8th Cir. 1978); and that all doubts are to be resolved against removal, *see, e.g., Abels v. State Farm Fire & Casualty Co.*, 770 F.2d 26, 29 (3d Cir. 1985); *Butler v. Polk*, 592 F.2d 1293, 1296 (5th Cir. 1979); *Jones v. General Tire & Rubber Co.*, 541 F.2d 660, 664-65 (7th Cir. 1976). *See generally* 14A C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 3721, at 216-17 (1985).

Consider what can happen if these principles are ignored and a standard other than obviousness is applied: A plaintiff brings a colorable state law claim in state court, electing to forgo an alternative federal cause of action that is available to him. The case is removed on grounds that the state claim is preempted and the federal court, in the face of conflicting authority and substantial uncertainty on the issue, denies a motion to remand, ruling that plaintiff's claim is, in reality, a federal one. The district court then proceeds to a judgment on the merits of the putative "federal" claim, as well as multiple pendant claims that are exclusively based on state law. If it is determined on appeal that removal was improper, the entire litigation has been for naught. Plaintiff, having been dragged into federal court despite his best efforts to limit his complaint to state law claims, is compelled to start from scratch in the forum that he originally selected. Of course, this scenario describes precisely what has happened in this case.<sup>12</sup>

None of these concerns is present where plaintiff has failed to assert a colorable state law claim. Plaintiff in those circumstances has not made a legitimate choice. If he had made the inquiry necessary to justify his selection of a state court forum, he would have quickly seen

<sup>12</sup> The scenario is a recurring one. *See, e.g., Hechler v. International Bhd. of Elec. Workers*, 772 F.2d 788 (11th Cir. 1985), *cert. granted*, No. 85-1360 (May 19, 1986).

that he had no state law on which to rely—he would have discovered that his claims were ineluctably federal. Moreover, the district court need not make any difficult legal determinations regarding federal preemption or the existence of a superseding federal cause of action if the law on these issues is already well-established.<sup>13</sup> It follows that the case will not have to be remanded once the court has assessed these questions, nor will the court's merits determination have to be vacated because it is subsequently found on appeal that the threshold removal decision was erroneous.<sup>14</sup>

Finally, the obviousness inquiry itself poses no difficulties in application. The federal courts have long relied on essentially the same standard for assessing whether federal jurisdiction has been properly invoked under the "substantiality" doctrine. See *Bell v. Hood*, 327 U.S. 678 (1946); *Hagans v. Lavine*, 415 U.S. 528 (1974).<sup>15</sup> The

<sup>13</sup> We do not mean to suggest that a claim is obviously federal only where this Court has already resolved the issue. Although that was the situation in *Avco*, a state law claim should be regarded as *not* obviously federal if the plaintiff can raise substantial arguments that it is not preempted or that there exists no alternative federal cause of action. Thus, this argument could fail even in a case of first impression, provided the relevant federal statute, in contrast to ERISA, is unambiguous with respect to its preemptive effect and its replacement of the state claim with a federal one.

<sup>14</sup> The Court has repeatedly relied on these sorts of practical considerations as a guide for defining the scope of removal jurisdiction. See *Franchise Tax Board*, *supra*, 463 U.S. at 20-21; *Gully v. First Nat'l Bank*, *supra*, 299 U.S. at 117.

<sup>15</sup> Like the obviousness standard, the substantiality doctrine has been drawn from the principle that the federal courts have the power to prevent the fraudulent invocation of their jurisdiction. See *Bell v. Hood*, *supra*, 327 U.S. at 682. This comparison finds additional support in the Court's citation to *Oneida Indian Nation v. County of Oneida*, 414 U.S. 661 (1974), in *Franchise Tax Board*, *supra*, 463 U.S. at 23 n.25. The plaintiffs in *Oneida* wanted to get into federal court and thus were asserting a federal claim. The question was whether they had a federal claim to assert, and the

range of the district court's inquiry about the validity of a state law claim for purposes of removal jurisdiction is no different than the inquiry about the validity of a federal law claim for purposes of original jurisdiction under the substantiality doctrine. In both, plaintiff's reliance on a given source of law is respected unless it is obvious that such reliance is misplaced. A federal court, in other words, must decline original jurisdiction where it is obvious that plaintiff *cannot* state a federal claim, and must accept removal jurisdiction where it is obvious that plaintiff *can only* state a federal claim.<sup>16</sup>

#### **B. Petitioners' Proposed Expansion of the Scope of Removal Jurisdiction is Based on a Misreading of this Court's Decisions.**

Petitioners argue that the district court in this case, upon receiving the removal petition, was compelled to disregard respondent's complaint and determine whether

Court found that it was valid for jurisdictional purposes under the substantiality doctrine. 414 U.S. at 666-67, 677. Just as plaintiff can get into federal court on the basis of a colorable federal claim, he should be able to avoid it on the basis of a colorable state law claim.

<sup>16</sup> Petitioners also argue that even if respondent's insurance contract claim is not preempted by federal law, it nonetheless should be characterized as within the district court's "original jurisdiction." Pet. Br. at 43-45. Stripped to its essentials, petitioners' contention amounts to nothing more than the proposition that, because respondent's claim under the insurance contract *could have* been brought directly under ERISA, his claim should be read as though it *was* brought under ERISA. That, however, is essentially the same claim that petitioners have made here with respect to removal jurisdiction based on a claim of preemption. Moreover, petitioners' theory would completely eviscerate the well-pleaded complaint doctrine by permitting removal even in the absence of preemption. Finally, there is nothing in the language of ERISA or its legislative history to suggest that the statute's provision relating to district court jurisdiction, § 502(a), 29 U.S.C. § 1132(e), was intended to amend section 1441 or to create a special exception to this Court's decisions construing the scope of removal jurisdiction.

his contract claim under the insurance policy was both preempted by ERISA and replaced by an ERISA cause of action. Petitioners further argue that, having resolved these issues in their favor, the district court was required to force respondent to assert his reconstituted federal cause of action, whether he wanted to or not.<sup>17</sup>

Petitioners claim to find support for this expansion of removal jurisdiction in *Avco Corp. v. Aero Lodge 735*, *supra*. They read *Avco* as a major exception to the well-pleaded complaint doctrine, authorizing removal even in the absence of "fraud" or "artful pleading." As we have shown, however, this view of the Court's decision in *Avco* simply ignores the already-settled nature of the preemption issue presented in that case. Removal to federal court in *Avco* was appropriate, not because district courts may discard the well-pleaded complaint doctrine in any case where a defendant argues that the plaintiff's state law claim is preempted by a federal law providing a substitute cause of action, but because the complaint was *not* well-pleaded in view of prior Supreme Court decisions clearly establishing the federal nature of the plaintiff's suit.<sup>18</sup>

<sup>17</sup> In theory respondent could have moved for voluntary dismissal of his "federal" claim, narrowing his suit to the remaining, and exclusively state law, claims against General Motors. Such a post-removal motion, however, would not have provided a basis for remand to state court. See 14A C. Wright, A. Miller & E. Cooper, *supra*, § 3738, at 558-59 & n.10.

<sup>18</sup> An additional factor favoring removal in *Avco*, but not present here, was the difference in remedies available at that time in § 301 suits, depending on whether the case was adjudicated in federal or state court. 390 U.S. at 560-61. Because the Norris-LaGuardia Act, 29 U.S.C. §§ 101-115, prohibited injunctive relief in § 301 actions in federal court, federal jurisdiction, while not exclusive, was plainly preferred. There is no such federal preference here, however. ERISA's jurisdictional provisions prescribe exclusive jurisdiction over certain types of claims, but expressly provide for *concurrent* jurisdiction over the type of claim that respondent is alleged to have asserted. ERISA § 502(e), 29 U.S.C. § 1132(e).

Petitioner's reconstruction of *Avco* was rejected in *Franchise Tax Board*, as the court below correctly held.<sup>19</sup> The *Franchise Tax Board* decision stresses the continuing viability of the well-pleaded complaint doctrine, 463 U.S. 9-13, and confirms that *Avco* must be interpreted as a "corollary" to that doctrine, *id.* at 22. Far from characterizing *Avco* as outside the fraud rule, *Franchise Tax Board* refers to *Avco* as an example of the rule. The Court noted that "*Avco* stands for the proposition that if a federal cause of action *completely* preempts a state cause of action, any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 23-24 (emphasis added).<sup>20</sup> The use of the term "completely," paralleling *Avco's* statement that section 301's applicability was "clear," necessarily describes the situation in which it is *obvious* that plaintiff can state only a federal claim. See *United Jersey Banks v. Parell*, 783 F.2d 360, 368 (3d Cir. 1986) (citing other cases). The qualifier "completely" in *Franchise Tax Board* must be disregarded to read the Court's language as supporting petitioners' theory.<sup>21</sup>

<sup>19</sup> In *United Ass'n of Journeymen v. Local 334*, 452 U.S. 615 (1981), and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the district courts apparently allowed removal on the basis of arguments similar to the preemption claim advanced by petitioners here. In neither case, however, did the plaintiff challenge the removal decision, and the propriety of removal was therefore not before this Court. See *Grubbs v. General Electric Credit Corp.*, 405 U.S. 699 (1972).

<sup>20</sup> Petitioners assert that *Franchise Tax Board* supports their theory because respondent's claim under the insurance contract "necessarily" arises under federal law in the same manner as the employer's claim in *Avco*. But the cause of action in *Avco* was necessarily a federal claim, not because it was found by the Court to be so in that decision, but because prior Supreme Court precedent had already settled the question unequivocally.

<sup>21</sup> Petitioners rely on a number of courts of appeals decisions that they assert support their position. Most of these cases, however, are actually consistent with our view of *Avco*. See, e.g.,

Petitioners' interpretation of *Avco* must be rejected for the separate reason that it is in direct conflict with the well-settled rule that a state law claim may not be removed to federal court on the basis of a federal defense, even if that defense is anticipated in plaintiff's complaint. See *St. Paul Mercury Indemnity Co. v. Red Cab Co.*, 303 U.S. 283, 291-92 (1938); *Gully v. First National Bank, supra*; *Louisville & Nashville Ry. v. Mottley*, 211 U.S. 149 (1908). As noted above, petitioners contend that a federal court, presented with a petition for removal on preemption grounds, is to undertake a two-step inquiry before translating plaintiff's state law claim into a federal one. First, the court must resolve whether plaintiff's state law claim is, in fact, preempted by federal law. If the court finds that the claim is preempted—and only if the court so finds—it then proceeds to the second, and separate, question of whether the assertedly preemptive federal law also creates a federal cause of action.

Petitioners cannot escape the fact that the first step in their proposed analysis requires the court to consider a defense of preemption. The defense of federal preemption is no different than any other defense for purposes of the rule precluding consideration of such matters in determining the propriety of removal. See *Franchise Tax Board, supra*, 463 U.S. at 11-12; *Gully v. First National*

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*Olguin v. Inspiration Consol. Copper Co.*, 740 F.2d 1468, 1472 (9th Cir. 1984) (following *Avco* in case where "[s]ettled precedent makes clear that each of Olguin's state cause of action are preempted by" § 301); *Eitmann v. New Orleans Pub. Serv., Inc.*, 730 F.2d 359, 365-66 (5th Cir.) (following *Avco* where "it is clear" that plaintiff's only right is governed by § 301), cert. denied, 105 S. Ct. 433 (1984). In addition, a number of courts of appeals have remanded where preemption was unclear. See, e.g., *Powers v. South Cent. United Food & Commercial Workers Unions & Employers Health & Welfare Trust*, 719 F.2d 760 (5th Cir. 1983); *Jones v. General Tire & Rubber Co., supra*, 541 F.2d at 577 n.10 ("we do not think the Supreme Court in *Avco* intended to effect a wholesale expansion of the federal courts' removal jurisdiction").

*Bank, supra*, 299 U.S. at 117.<sup>22</sup> And the insufficiency of the preemption defense as a basis for removal is not cured by the second step in petitioners' analysis. The second step is completely independent of the preemption inquiry, and is not even reached unless the federal court decides the preemption question in the defendant's favor. Under petitioner's proposed rule, the trigger for looking behind plaintiff's reliance on state law is the preemption defense. If a case may not be removed because of the mere assertion of a preemption defense, a federal court certainly cannot proceed to decide that defense simply because it is combined with the argument that federal law also creates an alternative claim.<sup>23</sup>

Petitioners' removal theory is, at best, only a minor variation on the argument rejected in *Gully v. First National Bank, supra*. In language that is equally applicable here, Justice Cardoza's opinion, holding that a preemption defense affords no basis for removal, emphasizes the need to limit the authority of the district courts to second-guess a plaintiff's reliance on state law. Likening the

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<sup>22</sup> ERISA preemption in this case resembles any other affirmative defense. If petitioners failed to raise it in the state court trial proceeding, the defense would have been waived. The preemption issue here can be contrasted, however, with *International Longshoremen's Ass'n v. Davis*, 54 U.S.L.W. 4512 (U.S. May 27, 1986), where federal law deprived the state court of jurisdiction and the preemption issue thus could be raised at any time.

<sup>23</sup> Nor is this a case in which the outcome would turn inevitably on questions of federal law. Here it is only "possible" that such questions would have figured prominently. See *Gully v. First Nat'l Bank, supra*, 299 U.S. at 118. If this case had remained in state court, defendants may have ignored the complicated preemption issue and defended on the merits. In *Franchise Tax Board, supra*, 463 U.S. at 26, the Court relied in part on this principle to find jurisdiction lacking, noting: "there are many reasons completely unrelated to the provisions and purposes of ERISA why the [plaintiff] may or may not be entitled to the relief it seeks." *Ibid.* The same observation counsels against removal here.

"arising under" inquiry to causation analysis, 299 U.S. at 118, the Court noted that, just as the source of a plaintiff's injury can be traced to remote and far-removed "causes," so too "countless claims of right" can be found to have "their source or operative limits" in federal law "[i]f we follow the ascent far enough." *Ibid.* Justice Cardozo reasoned that, "[t]o set bounds on the pursuit," the federal courts may not exercise removal jurisdiction simply because plaintiff's claim turns on a question of federal law, no matter how central to the dispute between the parties. *Ibid.*; accord *Pan American Petroleum Corp. v. Superior Court*, *supra*, 366 U.S. at 662-63; see also *Franchise Tax Board*, *supra*, 463 U.S. at 12 (removal is improper even if "the only question for decision is raised by [a] federal preemption defense"). The "ascent" against which Justice Cardozo warned would be followed virtually without limit under petitioners' theory.

In sum, the fraud exception to the well-pleaded complaint doctrine provides the only basis on which a federal court may look behind plaintiff's reliance on state law to determine whether the dispute, in actuality, "arises under" federal law. *Avco* does not create an additional exception, but clarifies that the fraud rule embraces the situation in which it is obvious that plaintiff's complaint can only state a claim under federal law. Because the ERISA preemption question in this case was anything but obvious, the Court of Appeal's decision was plainly correct.<sup>24</sup>

<sup>24</sup> Even if the Court accepts petitioners' argument that the district court has the power to replace a preempted state cause of action with a federal one, the Court should allow such replacement only where plaintiff's entire case rests on federal law. It is one thing to permit removal where plaintiff's entire suit is found to "arise under" federal law, as in *Avco*. In that situation it is reasonable to assume that the plaintiff would rather assert his federal claim in federal court than assert no claim at all. It is quite another matter, however, to permit removal of a case involving multiple state law claims, only one of which is potentially federal in nature. In that situation the plaintiff may wish to forgo

## II. RESPONDENT'S LAWSUIT WAS NOT REMOVABLE FOR THE SEPARATE REASON THAT HIS STATE LAW CLAIM UNDER THE INSURANCE CONTRACT WAS "SAVED" FROM FEDERAL PREEMPTION BY ERISA'S "SAVINGS CLAUSE" FOR STATE REGULATION OF INSURANCE.

We have thus far argued that the Court of Appeals, applying settled principles of removal jurisprudence, correctly held that respondent's state law claim for breach of the insurance policy could not be transformed into a federal claim under ERISA because it was not *obviously* federal. Should the Court reject this reasoning, however, the judgment below must nonetheless be affirmed for the separate reason that respondent's claim is not preempted by ERISA and, consequently, provides no basis for the district court's exercise of removal jurisdiction.

At issue here is the relationship, examined only last Term in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), between ERISA's basic preemption provision, section 514(a), 29 U.S.C. § 1144 (a), and its companion "savings clause," preserving state laws regulating insurance, section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Section 514(a) states broadly that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." Section 514(b)(2)(A) qualifies this provision, however, stating in equally broad and emphatic terms that section 514(a) shall not be "construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities" (emphasis added).

the federal cause of action, and to continue only with his state law claims in state court. That option is foreclosed once the district court has ruled—erroneously or not—that the allegedly federal claim is, in fact, federal. See note 17, *supra*. Thus, the district court should simply refrain from deciding the defendant's "preemption/replacement" argument in suits involving other claims that are concededly founded on state law alone.

Petitioners devote much of their brief to a discussion of ERISA's basic preemption provision. Again and again they stress the expansive language of section 514(a) and the broad preemptive effect that Congress intended it be given. Pet. Br. 11-20. This much is beyond question. See *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983). As the Court recognized in *Metropolitan Life*, however, Congress' intent with respect to the basic preemption provision says nothing about the meaning of a savings clause that, by its express terms, was designed to limit the preemption provision by placing certain categories of state law—including, specifically, those pertaining to insurance—beyond its reach.

Respondents' claims fall squarely within the protection of ERISA's savings clause, no less than the state insurance law at issue in *Metropolitan Life*. The savings clause was intended to preserve the states' traditional authority to regulate insurers and their relationship to policyholders, 105 S. Ct. at 2390-91, an authority vested in them by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. "Where, as here, the field which Congress is said to have preempted has been traditionally occupied by the States . . . 'we start with the assumption that the historic police powers of the states were not to be superseded by the Federal Act unless that was the clear and manifest purpose of the Congress.'" *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977), quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947). Petitioners' interpretation of ERISA turns this assumption on its head. If accepted, it would eviscerate the insurance savings clause as interpreted in *Metropolitan Life*.

*Metropolitan Life* involved a Massachusetts statute, a so-called "mandate" law, requiring all group health insurance sold within the state to contain minimum levels of coverage for a specified type of illness—mental illness, in the case of Massachusetts' law. Because most em-

ployers providing ERISA-regulated health benefits insured their plans through the purchase of group policies, the mandate law indirectly affected the content of their plans. Metropolitan Life and other insurers refused to comply, claiming that the mandate law was preempted by ERISA insofar as it applied to insurance purchased by ERISA-regulated welfare benefit plans. 105 S. Ct. at 2386. In a unanimous decision, this Court sustained the mandate law. The Court concluded that it was exempted from federal preemption by the savings clause for insurance.

The Court relied on the presumption "that Congress did not intend to pre-empt areas of traditional state regulation," *id.* at 2389, citing *Jones v. Rath Packing Co.*, *supra*, 430 U.S. at 525, as well as the "plain meaning" of the savings clause, 105 S. Ct. at 2389-91. The Court rejected the argument that the clause was addressed only to certain traditional types of insurance regulation, reasoning that such a construction could not be squared with the language of the clause or the McCarran-Ferguson Act's delegation to the states of plenary responsibility for regulating insurance. *Id.* at 2390-92. The Court also found that, although other exceptions to ERISA preemption were susceptible to a narrow interpretation, see *Shaw v. Delta Airlines, Inc.*, *supra*, 463 U.S. at 104 (construing section 514(d), 29 U.S.C. § 1444(d)), the exception for state insurance regulation was not. The Court emphasized that "the savings clause is broad on its face and specific in its reference." 105 S. Ct. at 2392 n.24 (emphasis added).<sup>25</sup> Indeed, ERISA's insurance clause

<sup>25</sup> The *Metropolitan Life* opinion repeatedly emphasizes the sweeping nature of ERISA's savings clause. The Court characterizes the clause as "broadly" preserving state laws regulating insurance. 105 S. Ct. at 2386. The opinion later observes that, while the basic preemption provision appears to broadly preempt most state laws, "the savings clause appears broadly to preserve the States' lawmaking power over much of the same regulations." *Id.* at 2389.

was found to be so far-reaching in effect that it saves not only state regulation in areas unregulated by ERISA, but also state regulations that overlap or supplement ERISA-imposed requirements on insured welfare plans. *Id.* at 2393.

*Metropolitan Life* controls the preemption question presented in this case, as the Court of Appeals for the Fifth Circuit recently held in *Dedaux v. Pilot Life Insurance Co.*, 770 F.2d 1311 (5th Cir. 1985), *petition for cert. filed*, No. 85-1043 (Dec. 16, 1985).<sup>26</sup> Here, as in *Metropolitan Life*, respondent has invoked state substantive law relating to insurance contracts in an effort to obtain benefits, and a declaration of rights to future benefits, from an insurance company that provides coverage for an ERISA-regulated employee benefit plan. It is hard to conceive of a clearer example of the type of insurance regulation that the states have traditionally exercised and that Congress intended to leave undisturbed by ERISA.

Petitioners advance a number of arguments in an effort to limit, distinguish and otherwise escape the holding of *Metropolitan Life*.<sup>27</sup> Petitioners contend, first,

<sup>26</sup> Moreover, virtually every other federal court to have considered the issue has similarly concluded that common law claims like respondent's are saved from preemption by ERISA's insurance clause. See *Lessard v. Metropolitan Life Ins. Co.*, *supra*, 618 F. Supp. at 1272; *Kanne v. Connecticut Gen'l Life Ins. Co.*, 607 F. Supp. 899, 905 (C.D. Cal. 1985); *Presti v. Connecticut Gen'l Life Ins. Co.*, 605 F. Supp. 163, 167 (N.D. Cal. 1985); *McLaughlin v. Connecticut Gen'l Life Ins. Co.*, 565 F. Supp. 434, 443-44 (N.D. Cal. 1983); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1168 (C.D. Cal. 1980). *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), is not to the contrary because it involved a self-insured plan, to which the savings clause does not apply. But see *Benvenuto v. Connecticut Gen'l Life Ins. Co.*, No. 84-3601 (D.N.J. Feb. 11, 1986) (holding that savings clause does not apply to tort and contract claims, involving principles of general applicability, against insurance companies).

<sup>27</sup> It should be noted that the Solicitor General's amicus brief in *Pilot Life*, *supra*, advances essentially the same preemption

that the savings clause does not apply to common law actions for breach of an insurance contract. Second, it is argued that suits like respondent's thwart Congress' intention to provide uniform federal regulation of ERISA plans. Third, petitioners claim that the state substantive law on which respondent's suit is based does not regulate the "business of insurance" within the meaning of the McCarran-Ferguson Act. And fourth, they contend that one portion of respondent's complaint seeks a benefit that is not insured and, as such, falls outside the scope of the savings clause.

While notable for their variety, these strained arguments in no way alter the conclusion that *Metropolitan Life* protects respondent's suit from ERISA preemption. We now address petitioners' claims *seriatim*.

#### A. The Savings Clause Applies to Common Law Contract Claims Against Insurance Companies.

In *Metropolitan Life* the insurers argued—without success—that the savings clause was meant to preserve only "traditional" types of state insurance laws, and should not be extended to the assertedly novel regulation of insurance benefits involved in that case. 105 S. Ct. at 2390-91. Ironically, the very same insurer now claims in this case that the savings clause must be confined to direct state enforcement of statutory requirements specifically applicable to insurance companies. The savings clause, it is argued, may not be extended to "traditional" contract actions between an insured and his insurer because such suits involve only common law doctrines of general applicability. Pet. Br. at 32-35. The argument fares no better when made in reverse.

arguments made by petitioners in this case, but frankly acknowledges that many of these claims are foreclosed by *Metropolitan Life*. See Amicus Curiae Brief of the United States, No. 85-1043, at 9-12 (filed May 30, 1986) (hereinafter referred to as "U.S. Br.").

### 1. Common Law Causes of Action as Insurance Regulation.

Petitioners' attempt to exclude state common law from the coverage of the savings clause flies in the face of ERISA's language. The "State laws" that are exempted from preemption under the savings clause are expressly defined to include, not only "laws" and "regulations," but also "decisions." ERISA § 514(c)(1), 29 U.S.C. § 1144(c)(1) (emphasis added). "[W]e assume 'that the legislative purpose is expressed by the ordinary meaning of the words used.'" *Kosak v. United States*, 465 U.S. 848, 853 (1984), quoting *American Tobacco Co. v. Patterson*, 456 U.S. 63, 68 (1982). In the context of ERISA's interrelated provisions pertaining to preemption, the word "decisions" can only be understood to mean the common law of state insurance regulation as developed in the decisions of state courts in tort, contract, and related actions against insurance companies.

Petitioners do not, and cannot, point to anything in ERISA suggesting that the term "decisions" in section 514(c)(1) refers to state "laws" other than judicial opinions resolving common law suits against insurers.<sup>28</sup> On the contrary, in court of appeals decisions applying ERISA's basic preemption provision, section 514(a), the word "decisions" has been consistently construed to mean common law actions for breach of contract, tortious conduct, and the like.<sup>29</sup> Obviously, the word "decisions" in

<sup>28</sup> Petitioners offer no explanation as to what the word "decisions" in ERISA means, yet they appear to argue that no common law causes of action are preserved by the savings clause. See Pet. Br. at 33-34 & n.9. But see U.S. Br. at 13 & n.11 (conceding that, in view of the term "decisions," the savings clause must be read as preserving at least some types of common law suits).

<sup>29</sup> See, e.g., *Holland v. Burlington Indus.*, 772 F.2d 1140, 1147 (4th Cir. 1985) (state common law actions for breach of contract), petition for cert. filed, No. 85-929 (Nov. 29, 1985), appeal docketed, 85-944 (Dec. 2, 1985); *Gilbert v. Burlington Indus.*, 765 F.2d 320, 326-28 (2d Cir. 1985) (common law actions arising

section 514(c)(1), defining both the scope of ERISA's preemption provision and the scope of the insurance savings clause, cannot mean common law actions in the former context, and something entirely different in the latter.

Nor can there be any doubt that suits for breach of contract and similar common law claims are regulatory in their purpose and effect. Common law suits imposing an "obligation to pay compensation can be, indeed [are] designed to be, a potent method of governing conduct and controlling policy." *San Diego Building Trades Council v. Garmon*, 359 U.S. 236, 247 (1959); see also *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 256 (1984). In the insurance context state court adjudication of common law actions against insurers is generally recognized as the *dominant* form of state regulation of insurance. See R. Keeton, *Basic Text on Insurance Law* § 8.1(b) (1971).<sup>30</sup> Indeed, petitioners' real concern is not that state law contract claims fail to regulate insurance, but that they *overregulate* insurance. Petitioners' construction of the insurance savings clause is thus precluded by the provision's plain meaning. The provision clearly ex-

out of employer's severance pay policy), appeal docketed, Nos. 85-441 and 85-460 (Sept. 16, 1985); *Authier v. Ginsberg*, 757 F.2d 796, 800 (6th Cir.) (common law cause of action for discharge in violation of public policy), cert. denied, 106 S. Ct. 208 (1985); *Blau v. Del Monte Corp.*, 748 F.2d 1348, 1356 (9th Cir. 1984) (common law actions for breach of contract, fraud, and deceit), cert. denied, 106 S. Ct. 183 (1985); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1214-16 (8th Cir.) (tortious interference with contract), cert. denied, 454 U.S. 968 (1981).

<sup>30</sup> "Courts, too, have had a significant role in the regulation of insurance transactions and institutions. A *very limited part of this role* is concerned directly with judicial proceedings for enforcement of regulatory measures initiated by a commissioner of insurance within authorizations granted by statute. *More significant* is the continuing role of the courts in the regulation of insurance transactions through doctrinal developments." R. Keeton, *supra*, § 8.1(b), at 543 (emphasis added).

tends to common law breach of contract claims like respondent's. Equally clearly, such claims regulate insurance.

Petitioners' proposed distinction between common law regulation of insurers and other forms of regulation fails for the additional reason that there is absolutely no basis for supposing that Congress meant to dictate to the states the particular mechanisms by which to enforce state policies and requirements applicable to insurers. Under petitioners' theory, a state is apparently free to regulate its insurers through administrative enforcement proceedings, government-initiated lawsuits, and perhaps other direct actions against insurers based on statutes focused on the insurance industry. However, the states may not create in favor of insureds a private cause of action sounding in contract, tort or other common law doctrines as a supplement to, or a substitute for, these regulatory mechanisms.

Congress could have tied the hands of the states in this way, divesting them of a form of regulatory control that they had traditionally exercised. But it is hard to imagine any reason why it would have done so, and it certainly should not be assumed that Congress took such a drastic step *sub silentio*. In enacting ERISA, Congress was presumably aware of the long history and pervasiveness of regulation of insurance companies through state court adjudication of common law claims. And there is no basis for supposing that, in its consideration of ERISA's preemptive effect, Congress viewed common law claims and doctrines developed by state courts as having a lesser stature than laws enacted by state legislatures or regulations promulgated by state agencies.

The untenability of petitioners' position can be seen by juxtaposing two states' systems for regulating insurers. State A elects to place this authority exclusively in the hands of a government insurance agency. All policy-

holders having disputes with their insurers are required to submit their claims to the agency. State employees adjudicate the claims, interpreting the insurance contract on the basis of past agency decisions and doctrines prescribed by regulation. The agency is empowered to force the insurer to pay contested benefits, and also to award damages and equitable relief. By contrast, State B provides the same degree of regulatory oversight and enforcement power, but elects to delegate all authority for these matters to the state judiciary. It simply makes no sense to conclude, as petitioners urge, that the former scheme is saved from ERISA preemption while the latter is not. If a state is free to have these cases decided by bureaucrats, it is also free to have them decided by judges.<sup>31</sup>

## 2. Common Law Doctrines Governing Insurance Claims As Distinguished from Doctrines of General Applicability.

Petitioners' interpretation of the savings clause rests on the conclusory assertion that common law contract claims for breach of an insurance policy involve only "doctrines of general applicability" that would govern the "parties to any form of contract." Pet. Br. at 33; accord U.S. Br. at 13-18. But this characterization of common law suits in the insurance context is simply wrong. As we show, contract claims against an insurer are litigated against the backdrop of a variety of statutory policies, reflecting important state choices concerning insurers' obligations to their policyholders. And they

<sup>31</sup> Indeed, petitioners' conclusion is contrary to the usual presumption applied in assessing the scope of federal preemption. In *Silkwood v. Kerr-McGee*, *supra*, for example, it was assumed by all parties and the Court that Oklahoma was barred from regulating the safety of nuclear power plants by statute or regulation. Nonetheless, the Court held that the preemptive effect of the Atomic Energy Act, 42 U.S.C. §§ 2011-2296, did not preclude a tort claim for compensatory and punitive damages against a federally-regulated utility.

are subject to specialized common law doctrines that are peculiar to the contractual relationship between an insured and his insurer and operate to regulate that relationship far more closely than the relationship between parties to other contracts.

In Michigan—whose substantive law of insurance contracts respondent wishes to invoke—insurers are not only required to comply with express statutory requirements, *see, e.g., Siller v. Employers Insurance*, 123 Mich. App. 140, 333 N.W.2d 197 (1983), *Dasen v. Frankenmuth Mutual Insurance Co.*, 39 Mich. App. 582, 197 N.W.2d 835 (1972), *Galkin v. Lincoln Mutual Casualty Co.*, 279 Mich. 327, 272 N.W. 694 (1937), but their contracts will be construed, and often judicially rewritten, in light of the courts' perception of state policy in a given area. For example in *Blakeslee v. Farm Bureau Mutual Insurance Co.*, 388 Mich. 464, 201 N.W.2d 786 (1972), Michigan's policy in favor of maximizing automobile liability coverage in accidents involving uninsured motorists permitted the plaintiff to "pyramid" his coverage for such losses under two separate policies, notwithstanding a "setoff" provision in both policies precluding that result. *Accord Bradley v. Mid-Centry Insurance Co.*, 409 Mich. 1, 294 N.W.2d 141 (1980); *Boettner v. State Farm Mutual Insurance Co.*, 388 Mich. 482, 201 N.W.2d 795 (1972); *Pappas v. Central National Insurance Group*, 400 Mich. 475, 255 N.W.2d 629 (1977).

Judicially created common law doctrines of insurance contract interpretation are even more regulatory in their application. Michigan insureds have the benefit of a common law rule under which ambiguities in an insurance policy are to be strictly construed against the insurer. *See, e.g., Crowell v. Federal Life & Casualty Co.*, 61 Mich. App. 377, 232 N.W.2d 710 (1975), *aff'd*, 397 Mich. 617, 247 N.W.2d 503 (1976); *Michigan Mutual Insurance Co. v. Sunstrum*, 111 Mich. App. 98, 315 N.W.2d 154 (1981); *Cates v. Moyses*, 57 Mich. App. 405,

226 N.W.2d 106 (1975). This doctrine, adopted in virtually every jurisdiction, *see A. Windt, Insurance Claims and Disputes* § 6.02 at 226-28 (1982),<sup>32</sup> often has the effect of imposing obligations on insurers that are nowhere to be found in their policies. In *Crowell v. Federal Life and Casualty Co.*, *supra*, for example, the plaintiff was found to have a "confining illness" within the meaning of the policy, thus entitling him to life-time disability benefits, even though his disability did not confine him to his residence, as explicitly required by the terms of the policy. Similarly, in *Niagara County v. Utica Mutual Insurance Co.*, *supra*, a case involving a municipality's liability for the "Love Canal" chemical pollution, a policy provision conditioning coverage for such liability to "sudden" discharges of pollutants was found to be no bar to the plaintiff's recovery because it had discovered the polluting condition "suddenly."

And Michigan courts have gone a step further, applying a doctrine under which insurance policies are interpreted to give effect to the insured's "reasonable expectations," even in the absence of ambiguity, and even if such expectations are directly contrary to the express terms of the policy. Thus, in *Herring v. Golden State Mutual Life Insurance Co.*, 114 Mich. App. 148, 318 N.W.2d 641 (1982), the court disregarded express limitations in a disability insurance policy, finding that the plaintiff reasonably would have expected that his disabling condition would be treated as a "total disability" under the contract. *Accord Bradley v. Mid-Century In-*

<sup>32</sup> *See, e.g., MFA Mut. Ins. Co. v. State Farm Mut. Ins. Co.*, 268 Ark. 746, 595 S.W.2d 706, 709 (Ark. App. 1980) (ambiguity should be resolved so as to provide coverage "unless it is patently unreasonable to do so"); *Niagara County v. Utica Mut. Ins. Co.*, 103 Misc.2d 814, 427 N.Y.S.2d 171, 176 (1980), *aff'd*, 439 N.Y.S.2d 538 (1981) (in the event of an ambiguity, the court must accept the interpretation most favorable to the insured and "cannot engage in efforts to determine which interpretation might be most reasonable").

insurance Co., *supra*, 294 N.W.2d at 163-64. The "reasonable expectations" rule, unique to contract disputes in the insurance area, has also been adopted in other states.<sup>33</sup> In *Collister v. Nationwide Life Insurance Co.*, *supra*, for example, an applicant for life insurance, killed in an automobile accident before the application was accepted, was found to have an enforceable policy despite the fact that this was disclaimed on both the application form and the receipt given the applicant, and despite the fact that he had not submitted to a medical examination—an express contractual precondition for coverage. See also *Olszak v. Peerless Insurance Co.*, *supra*.

These highly specialized principles of contract interpretation governing private litigation in the insurance area simply cannot be characterized as doctrines of "general applicability" that would apply in any suit alleging a breach of contract. They are peculiar to the insurance industry and they are highly regulatory of the industry. And while these specialized doctrines may not apply to every aspect of every claim against an insurer, the Court should reject any reformulation of ERISA's savings clause that would permit preemption of suits involving doctrines of general applicability, and leave intact contract and other common law claims governed by specialized doctrines. Such a rule would create impossible line-drawing problems, spawning repeated appeals to this

<sup>33</sup> See, e.g., *Stordahl v. Government Employees Ins. Co.*, 564 P.2d 63, 66 (Alaska 1977); *Stewart v. Estate of Bohnert*, 101 Cal. App. 3d 978, 162 Cal. Rptr. 126, 131-32 (1980); *Otter v. General Ins. Co.*, 34 Cal. App. 3d 940, 109 Cal. Rptr. 831, 837 (1973); *Corgatelli v. Globe Life & Accident Ins. Co.*, 96 Idaho 616, 533 P.2d 737, 742 (1975); *C & J Fertilizer Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169, 176-77 (Iowa 1975); *Olszak v. Peerless Ins. Co.*, 119 N.H. 686, 406 A.2d 711, 713 (1979); *Kievit v. Loyal Protective Life Ins. Co.*, 34 N.J. 475, 170 A.2d 22, 26-27 (1961); *Collister v. Nationwide Life Ins. Co.*, 479 Pa. 579, 388 A.2d 1346, 1353 (1978), cert. denied, 439 U.S. 1089 (1979).

Court for resolution of ostensibly federal questions that would inevitably turn on the interpretation and application of state law. These line-drawing problems would be especially acute in the removal context because the fine distinctions required of the district court would have to be made at the very threshold of the case, before the development of a factual record and briefing on the merits of the parties' claims and defenses. At that stage only the most clairvoyant district judge could draw petitioners' proposed line in the right place.<sup>34</sup>

In short, there is no justification for carving out an exception to ERISA's savings clause for state common law actions against insurers. Such an exception is contrary to the plain meaning of the statutory language; is without support elsewhere in the Act or its legislative history; and is based on an asserted distinction between different types of state law claims that, if not completely illusory, is impossible to apply in practice.

#### **B. State Common Law Claims Against Insurers Do Not Conflict With the Regulatory Scheme Created By ERISA.**

Petitioners contend that state law contract claims for benefits provided under insurance policies would undercut Congress' intention of creating a single, uniform body of federal law governing the regulation of ERISA plans. Application of the insurance savings clause to lawsuits such as respondent's, it is argued, would subject

<sup>34</sup> Should the court nonetheless adopt the line-drawing test proposed by petitioners and the Solicitor General, see U.S. Br. at 15-16, this case should be remanded for a determination of whether respondent's claim for breach of his insurance contract involves the application of common law doctrines of "general applicability." The district court's decision sheds no light on this question because, having accepted petitioners' preemption argument, it presumably treated respondent's claim as one arising under ERISA, not state contract law.

ERISA plans to potentially different standards imposed by different states. Pet. Br. at 37-42.

The short answer to this claim is that precisely the same argument was made in *Metropolitan Life*—and squarely rejected. The insurers there argued that failure to construe the savings clause as preempting state mandate laws would create substantial “disuniformities” in the design and administration of ERISA plans. 105 S. Ct. at 2393. The insurers pointed out that multi-state employers would have to tailor their plans to the particular mandate laws of each state in which they do business. They also noted that, because of the operation of ERISA’s “deemer clause,” section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), the mandate laws of any particular state would apply fully to insured ERISA plans, but would not govern the self-insured plans of large employers. *Ibid.* Petitioners’ arguments here simply recycle these discredited claims. The appropriate response is that given in *Metropolitan Life*: “[these] disuniformities . . . are the inevitable result of the congressional decision to ‘save’ local insurance regulation.” *Ibid.*

In an attempt to distinguish *Metropolitan Life*, petitioners claim to find preemptive force in section 502 of ERISA, 29 U.S.C. § 1132, which provides specific remedies for violations of the trust relationships established by the statute, including a federal claim by a plan beneficiary “to recover benefits due to him under the terms of his plan.” ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Petitioners argue that state law claims like respondent’s would conflict with the section 502(a)(1)(B) remedy, which was modeled on section 301 of the Labor Management Relations Act, 29 U.S.C. § 185. Petitioners stress that section 502 actions in federal court “are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301.” H.R. Conf. Rep. No. 93-1280, 93d Cong.

2d Sess. 327 (1974). On this basis petitioners conclude that any claim that *could have* been brought under section 502 is preempted by section 502 itself, irrespective of ERISA’s basic preemption provision. Pet. Br. at 19, 40-41; *see also* U.S. Br. at 18-19.<sup>35</sup>

The argument is misconceived. To begin with, Congress’ reference to section 301 in ERISA’s legislative history was *not* meant to suggest that section 502 of ERISA has any independent preemptive effect, apart from section 514(a). The analogy to section 301 simply clarifies that actions brought under section 502, like actions brought under section 301, are to be governed by federal common law as developed through case-by-case adjudication in the federal courts. It is this aspect of section 301 litigation to which ERISA’s legislative history refers, and which was intended to be carried forward in section 502. The result is that *if* a case is brought under section 502, it will be adjudicated under federal common law principles.

<sup>35</sup> Petitioners also contend that even if respondent’s claim is saved from preemption by ERISA’s savings clause, his lawsuit nonetheless must be seen as falling within the federal court’s original jurisdiction. Pet. Br. at 43-45. We have already explained that this theory would eviscerate the well-pleaded complaint doctrine. *See* note 16, *supra*. But the argument is flawed in this context for the separate reason that it is fundamentally circular. Petitioners contend that respondent’s claims contain a “federal law element” because “his rights are defined by reference to [an ERISA-regulated] plan and the matrix of federal regulations which surrounds it.” Pet. Br. at 45 n.12. But this argument presupposes that respondent’s claims are indeed preempted by ERISA. If they are not preempted—as petitioners assume for purposes of this argument—federal law is simply irrelevant to respondent’s claims. Similarly, petitioners argue that Congress intended “to provide ready access to the federal courts in ERISA benefit cases.” Pet. Br. at 45. Respondent’s lawsuit, however, is not an ERISA benefit case, but an insurance contract case. It would only be an ERISA benefit case if respondent’s state law actions were preempted—which, by hypothesis, they are not.

To be sure, section 301 does have preemptive effect. But that is only because the Labor Management Relations Act contains no express preemption provision. Petitioners' argument would have some force if ERISA, like the labor law, was silent on the question of preemption, thus requiring this Court to mark out the boundaries of exclusive federal regulatory authority necessary to effectuate congressional purposes. But Congress has itself drawn these boundaries in ERISA, and has done so with a degree of precision and specificity that is unusual, if not unique, in federal legislation. Under these circumstances neither section 502 nor any other provision of ERISA can be read as expanding the scope of preemption prescribed in the statute's carefully delineated preemption provisions.<sup>36</sup>

**C. Preserving Respondent's Contract Claim for Insurance Benefits Is Consistent With the McCarran-Ferguson Act.**

In support of their theory that an insured's contract claim for benefits against an insurance company is not a species of insurance regulation for purposes of ERISA's savings clause, petitioners also contend that such private litigation does not concern the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* The argument is without merit.

<sup>36</sup> In any case, it is by no means self-evident that state law contract and similar common law claims are disruptive of the remedial scheme provided in § 502. Although ERISA's legislative history sheds little light on the savings clause, it is likely that Congress intended state common law actions to *supplement* ERISA remedies in this area. Congress had virtually no experience in the regulation of insurance at the time ERISA was enacted; the states, by contrast, had developed long-standing statutory and common law systems of regulating insurers. Congress thus chose to provide only minimal remedies for plan beneficiaries under § 502, while leaving intact the pre-existing system of state regulation to assure that policyholders would be adequately protected. See *Metropolitan Life*, *supra*, 105 S. Ct. at 2393 (savings clause intended to preserve even state regulation of activities also regulated by ERISA).

Petitioners' argument is based on recent decisions of this Court establishing criteria for determining whether certain economic activities or arrangements constitute the "business of insurance" within the meaning of McCarran-Ferguson. In *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), on which petitioners primarily rely, the Court held that the "business of insurance" did not include peer review practices used by an insurer to determine the compensability of health insurance claims. The Court reasoned that peer review, unlike insurance *per se*, does not operate to spread the risk of loss; is not an integral part of the policy relationship between an insurer and its insureds; and is not limited in its impact to entities within the insurance industry. *Id.* at 129-34, see also *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211-32 (1979) (applying the same criteria).

Petitioners' use of these criteria misses the point. To begin with, the *Metropolitan Life* decision, while recognizing that the ERISA savings clause "appears" to have been designed to preserve the authority ceded to the states by McCarran-Ferguson, 105 S. Ct. at 2392 n.21, did not hold that the scope of the savings clause was coextensive with McCarran-Ferguson. The Court looked to McCarran-Ferguson to bolster its "conclusion that regulation regarding the substantive terms of insurance contracts falls squarely within the savings clause." *Id.* at 2391. Thus, state laws that do not regulate the "business of insurance" within the meaning of McCarran-Ferguson may nonetheless be saved from preemption under ERISA's savings clause. The former is limited to the regulation of the "business of insurance" while the latter is not.<sup>37</sup>

<sup>37</sup> Thus, for example, the mere applicability to an insurer of a state insurance regulation would not necessarily qualify the insurer for McCarran-Ferguson's antitrust exemption, 15 U.S.C. 1013(a) & (b). See, e.g., *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978). However, even petitioners would

In any case, there can be little question that respondent's breach of contract claim is embraced by McCarran-Ferguson's definition of the "business of insurance." The focus of the Michigan insurance contract law that respondent wishes to invoke is the interpretation of his policy and the contractual relationship between respondent and the insurer. This is the very "core of the 'business of insurance.'" *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). When enacting the McCarran-Ferguson Act, "Congress was concerned with the type of state regulation that centers around the contract of insurance, . . . [t]he relationship between the insurer and the insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." *Ibid.* The specialized criteria articulated in the *Pireno* case were developed primarily to determine whether certain economic activities or arrangements that are not themselves "insurance," but are *ancillary* to the design and administration of insurance, may nonetheless be seen as the "business of insurance" under McCarran-Ferguson. The criteria need not be applied at all where, as here, the entire underlying dispute revolves around the interpretation of an insurance policy. This case concerns not activities *ancillary* to insurance, but insurance itself.

But even if the McCarran-Ferguson criteria relied on by petitioners were controlling, they are clearly met in this case. Respondent's suit is a claim against an insurer

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concede that the same regulation, if focused specifically on insurers, would be saved from ERISA preemption by the insurance savings clause. Moreover, the lack of congruence between McCarran-Ferguson and ERISA's savings clause is demonstrated by the fact that the former refers only to laws "enacted by" a state, 15 U.S.C. § 1012(b), while the latter preserves both statutes and *decisional* law. See page 32, *supra*. For this reason the Solicitor General acknowledges that the McCarran-Ferguson criteria relied on by petitioners are not determinative of whether a particular form of state insurance regulation is subject to ERISA's savings clause. See U.S. Br. at 17-18.

for benefits under an insurance policy. That policy obviously operates to spread risk among insureds; indeed, that is its very purpose. Similarly, the terms of that policy are an integral part of the relationship between respondent and petitioners—the second criterion set out in *Pireno*. And finally, any questions concerning the interpretation of the insurance policy, and state substantive law governing those questions, are plainly limited in their impact to entities within the insurance industry.<sup>38</sup>

**D. The Aspect of Respondent's Contract Claim Seeking a "Salary Continuation Benefit" Is Not Preempted by ERISA.**

Petitioners argue that even if the insurance savings clause "saves" most of respondent's benefit claims from preemption under section 514(a), one of the benefits that respondent seeks is uninsured and, for that reason, beyond the scope of the savings clause. The claim in question is for compensation under General Motors' "Salary Continuation Benefit" program, which petitioners contend is financed exclusively out of General Motors' "current revenues." Pet. Br. at 46. The argument is based on the law as petitioners wish it were; not as it is.

At the outset, it should be noted that there is nothing in the record of this case, other than the unsworn assertions of petitioners' attorneys, to support the argument that this particular benefit, unlike all the others provided under General Motors' employee benefit plan, is funded entirely from the company's general revenues. Assuming, however, that this benefit is in fact set up in the manner described by petitioners, any state law claim seeking payment of the benefit is not preempted for the reason that employer-provided benefits funded from general

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<sup>38</sup> To be sure, the litigation may also have an indirect effect on General Motors, but the same is true with respect to employers purchasing insurance subject to the mandate law at issue in *Metropolitan Life*.

revenues—specifically including salary continuation benefits—are not regulated by ERISA at all. Because they are unregulated by ERISA, a state law contract suit seeking these benefits obviously cannot “relate to” an ERISA-covered plan within the meaning of the statute’s basic preemption provision.

On the theory that benefits payable out of an employer’s general revenues do not usually require federal supervision under ERISA, see 40 Fed. Reg. 24,642-43 (1975), the Department of Labor has promulgated regulations pursuant to section 505 of ERISA, 29 U.S.C. § 1135, expressly exempting from ERISA coverage most benefits of this type, 29 C.F.R. § 2510.3-1(b). The particular benefit on which petitioners rely is exempted by 29 C.F.R. § 2510.3-1(b)(2). It states in relevant part that:

The terms “employee welfare benefit plan” and “welfare plan” shall not include . . . [p]ayment of an employee’s normal compensation, out of the employer’s general assets, on account of periods of time during which the employee is physically or mentally unable to perform his or her duties, or is otherwise absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment).

Petitioners’ brief is notable for the absence of even a single mention of this dispositive regulation. We assume that petitioners know of section 2510.3-1(b), since their pension lawyers presumably designed the Salary Continuation Benefit as a “general assets” plan in order to avoid ERISA regulation. In any case there is no reason to doubt the validity of section 2510.3-1(b). The Court of Appeals for the Ninth Circuit recently sustained the Department of Labor’s companion regulation, 29 C.F.R. § 2510.3-1(b)(3)(i), which exempts employer-paid compensation to employees who are on vacation. *California Hospital Association v. Henning*, 770 F.2d 856 (9th Cir. 1985). The Court’s well-reasoned decision held that the

exclusion of such “general assets” plans was well within the Department’s discretion to interpret ERISA’s coverage provisions.<sup>39</sup>

Petitioners’ argument relating to the salary continuation plan must be rejected for the separate reason that respondent’s state law claim for payment of this benefit was made against Metropolitan Life, not General Motors. The benefit is mentioned only in Count II of respondent’s original complaint, which seeks relief against Metropolitan Life exclusively. J.A. 22-24. This was made clear by respondent at the time of his motion to remand. J.A. 38, 41; Rec. A-44. And, although he was given an opportunity after removal to restate the claim as one directed against General Motors, respondent’s amended complaint simply reconfirmed that Count II of his complaint, the only section in which the salary continuation plan is mentioned, seeks relief from Metropolitan Life alone. J.A. 237.<sup>40</sup> Under these circum-

<sup>39</sup> Nor is there any basis for the argument advanced by amicus, the “ERISA Industry Committee,” that the salary continuation plan, although itself immune from ERISA regulation, becomes subject to ERISA when combined with other plans that are covered by the statute. Amicus Br. at 8 n.9. The regulation, 29 C.F.R. § 2510.3-1(a)(2), and statutory provision, 29 U.S.C. § 1002(1)(A), cited by amicus contain not a shred of support for this interpretation.

<sup>40</sup> Similarly, it cannot be argued that, because respondent’s original complaint alleged “joint and several liability” on the part of petitioners, J.A. 19, Count II may be seen as demanding relief from General Motors. Indeed, in its answer to the original complaint, General Motors made “no response” to respondent’s allegations concerning the unlawful termination of benefits “because said paragraph[s] [are] directed against Defendant Metropolitan Life.” J.A. 29. Moreover, if the “joint and several liability” averment meant that Count II applied to General Motors, it would follow that Count I of the complaint, alleging retaliatory discharge by General Motors, seeks damages from Metropolitan Life. Such an interpretation of the complaint obviously makes no sense. Certainly Metropolitan Life would not contend that it is potentially liable for the claims asserted in Count I of respondent’s complaint.

stances the portion of respondent's contract claim seeking salary continuation benefits is saved from preemption to the same extent, and for the same reason, as all other aspects of his breach of contract claim. This is so because the claim seeks recovery from an insurance carrier, not from respondent's employer. As such, the claim is subject to ERISA's savings clause, whether or not Metropolitan Life possessed the authority to grant or deny the requested coverage.

In short, any distinctions between the benefits that are payable under the salary continuation plan and other aspects of General Motors' welfare benefit plan provide petitioners with no escape from the holding of *Metropolitan Life*.<sup>41</sup>

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<sup>41</sup> Even if the Court agrees with petitioners that ERISA's savings clause does not extend to respondent's claim for breach of his insurance policy, it is by no means clear that respondent has stated a claim under ERISA § 502—a necessary precondition for the exercise of federal question jurisdiction. Respondent's contract claim against Metropolitan Life can only be deemed an ERISA claim if Metropolitan Life is a "fiduciary" with respect to General Motor's plan. See *Eversole v. Metropolitan Life Ins. Co.*, *supra*. The relevant statutory provision, 29 U.S.C. § 1002(21)(A), and regulation, 29 C.F.R. § 2560.503-1(g)(2), define a fiduciary as, *inter alia*, an entity that exercises discretion with respect to the administration of the plan or the disposition of its assets.

It is uncertain on the record of this case whether Metropolitan Life meets this test. General Motors' benefits manual states that General Motors, not Metropolitan Life, is both the "named fiduciary" and "administrator" of all plans. J.A. 155. And, although Metropolitan Life apparently exercised some role in denying respondent's disability benefits, the nature of that role is ambiguous in view of the Court of Appeals' observation that, following the insurer's decision to terminate respondent's benefits, respondent was still required to undergo a further medical examination by General Motors. GM Pet. App. 3a. It follows that even if ERISA's savings clause does not preserve respondent's claims, this case must be remanded for a determination as to Metropolitan Life's fiduciary status.

## CONCLUSION

For the foregoing reasons, the decision of the Court of Appeals should be affirmed.

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# REPLY BRIEF

Nos. 85-686 and 85-688

Supreme Court, U.S.  
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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1986

GENERAL MOTORS CORPORATION and  
METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioners,*

v.

ARTHUR TAYLOR,  
*Respondent.*

On Writs of Certiorari to the United States  
Court of Appeals for the Sixth Circuit

**REPLY BRIEF FOR PETITIONERS  
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**REPLY BRIEF FOR PETITIONERS  
GENERAL MOTORS CORPORATION AND  
METROPOLITAN LIFE INSURANCE COMPANY**

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**I. Introduction**

Petitioners have demonstrated in their opening brief that several provisions of ERISA support removal of this case. Whatever state law principles respondent may invoke, his claims for benefits under an ERISA-covered employee welfare benefit plan fall within the literal scope of Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), which provides a federal cause of action that Congress intended to be exclusive. Section 502(a), standing by itself, preempts any state law cause of action that respondent may allege in this case and replaces it with a superseding federal cause of action. In addition, by its express terms, Section 514(a) of ERISA, 29 U.S.C. 1144(a), broadly preempts the state law cause of action that respondent seeks to assert.

Respondent's claim for benefits also falls within the original jurisdiction of the district court by virtue of Section 502(f) of ERISA, 29 U.S.C. 1132(f), which grants federal district courts jurisdiction over all claims for benefits under an ERISA-covered plan, whether the plaintiff purports to base his complaint on federal or state law, and "without respect to the amount in controversy or the citizenship of the parties." As Congress made clear in Section 2(b) of ERISA, 29 U.S.C. 1001(b), this broad grant of original jurisdiction was central to the legislative plan to guarantee "ready access to the Federal courts" in all ERISA cases.

This Court's recent decision in *Merrell Dow Pharmaceuticals, Inc. v. Thompson*, — U.S. —, 106 S. Ct. 3229 (July 7, 1986), confirms the propriety of removal under the foregoing statutory provisions. By a 5 to 4 vote, the Court held in *Merrell Dow* that a complaint based on state law, which alleged a violation of a federal standard deriving from the Federal Food, Drug and Cos-

metic Act, could not be removed to federal court unless Congress granted a private federal remedy to the plaintiff. The majority stated that "[t]he significance of the . . . assumption that there is no federal private cause of action . . . cannot be overstated." 106 S. Ct. at 3234. Four Justices, dissenting on other grounds, pointed out in *Merrell Dow* that "[u]nder the Court's analysis . . . if a party persuaded a court that there is a private cause of action under the FDCA, there would be federal jurisdiction. . . . Such jurisdiction would apparently exist even if the plaintiff did not seek the federal remedy." 106 S. Ct. at 3241 n. 4. Likewise, in the present case, the significance of the fact that Congress *has* granted a federal remedy cannot be overstated.

Beyond this, Congress has conferred a federal cause of action that it meant to be exclusive; it has expressly preempted all state law causes of action that Taylor may assert; and it has unambiguously declared its purpose to grant "ready access to the Federal courts" without regard to diversity of citizenship or the amount in controversy. In these circumstances, we submit, the majority and dissenting opinions in *Merrell Dow* remove any doubt about the propriety of removal.

As we demonstrate in this reply brief, respondent has failed to come to grips with the critical fact that Congress intended complaints such as his to be freely filed in—and freely removed to—federal court. His objections to removal are without merit and should be rejected by the Court.

**II. There Is No Support For Respondent's Contention That Cases Are Removable To Federal Court Only If The Basis For Removal Is "Obvious" At The Time Of Removal.**

Respondent contends at length (Br. 11-21) that petitioners improperly removed this case to federal court because, "at the time of removal, it was not obvious that his claim under the insurance contract could only be stated under federal law" (*id.* at 12). However, no

court has ever endorsed such a subjective and utterly unworkable criterion for removability. In fact, *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968), a case that is referred to at length in petitioners' opening brief and which respondent attempts to distinguish to support his theory of removability, clearly demonstrates how meritless that theory is.

A. In *Avco*, this Court sustained removal even though at the time the case was removed it was not at all "obvious" that the case was subject to removal. In *Avco*, the lower courts sharply disagreed on the issue of removability. This Court granted certiorari (390 U.S. at 559) to resolve a conflict between the Sixth Circuit in *Avco Corp. v. Aero Lodge No. 735*, 376 F.2d 337 (6th Cir. 1967), and the Third Circuit in *American Dredging Co. v. Local 25*, 338 F.2d 837 (3d Cir. 1964).

In both *Avco* and *American Dredging*, the plaintiffs filed suit in state court under state law to enjoin union members from striking in violation of their collective bargaining agreements. Neither complaint made mention of federal labor law. Nonetheless, the defendants in each case removed the suits to federal court.

The Sixth Circuit sustained removal, concluding that the complaint necessarily arose under Section 301 of the Labor-Management Relations Act by virtue of the preemptive impact of that provision. 376 F.2d at 340-343. By contrast, the Third Circuit held that the plaintiff's claim rested solely on state law and therefore could not be removed to federal court. 338 F.2d at 840-850.

This Court affirmed the Sixth Circuit's decision in *Avco* and rejected the Third Circuit's decision in *American Dredging*. In resolving the conflict among the circuits, it held that the complaints arose under federal law by reason of federal preemption and therefore were properly removed. If respondent were correct in now contending that removal is proper only when the basis

for removal is "obvious" at the time of removal, this Court never could have sustained removal in *Avco*.<sup>1</sup>

B. In addition to being contrary to established precedent, respondent's "obviousness" test would be completely unworkable in practice and destructive of the goal of uniformity of interpretation of federal law. To make removal turn on an inquiry into the "obviousness" of the basis for removal would encumber the removal statute with uncertainty and seriously restrict the ability of federal courts to settle disputed issues of federal law.

In *Merrell Dow*, *supra*, the Court majority warned against the adoption of vague legal standards under the federal removal statute. The Court noted that the proper management of the federal judicial system "would be ill-served by a rule that made the existence of federal-question jurisdiction depend on the district court's case-by-case appraisal of the novelty of the federal question asserted." 106 S. Ct. at 3237. Like the vague standard of "novelty" rejected in *Merrell Dow*, the standard of "obviousness" now proposed by respondent would only hinder the efficient administration of the federal removal statute.

At the same time, foreclosing removal unless the removing party demonstrated an "obvious" basis for removal would severely curtail access to federal court in a large number of important cases, as the *Avco* litigation illustrates. Indeed, such a standard, in practical

<sup>1</sup> Contrary to respondent's suggestion (Br. 12-13), the decision in *Avco* sustaining removal did not turn on the presence of any effort by the plaintiff to avoid the jurisdiction of the federal courts through "fraudulent means." Rather, the plaintiff in *Avco* simply sought a remedy in state court that appeared to be available only under state law.

Inexplicably, respondent cites (Br. 13) a series of irrelevant decisions from this Court dealing with "fraudulent joinder," including *Chicago, Rock Island Ry. Co. v. Schwyhart*, 227 U.S. 184 (1913). That case involved the joinder of non-diverse parties and the issue was whether the joinder was fraudulent. The present case is not a "fraud" case; nor does it involve removal based on diversity of citizenship.

operation, would require a decision from this Court before a case could be removed to the district court. This would defeat the goal of uniformity that Congress intended to secure by vesting the district courts with original and removal jurisdiction in *all* cases arising under federal law. See ALI, *Study of the Division of Jurisdiction Between State and Federal Courts*, 164-168 (1969).

Justices Brennan, White, Marshall and Blackmun, dissenting on other grounds in *Merrell Dow*, explained that federal courts are better equipped than state courts to resolve federal statutory issues because they "are comparatively more skilled at interpreting and applying federal law, and are much more likely correctly to divine Congress' intent in enacting legislation." 106 S. Ct. at 3242. That consideration applies *a fortiori* under ERISA, in which Congress took pains to guarantee "ready access to the Federal courts." 29 U.S.C. 1001(b).

C. Rather than relying on the nebulous "obviousness" test proposed by respondent, this Court should look to the literal language of the removal statute and its own recent decisions construing it. Under 28 U.S.C. 1441(a), Congress has provided that "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed" to federal court. And, under 28 U.S.C. 1441(b), any civil action "founded on a claim or right arising under the . . . laws of the United States shall be removable."

As this Court explained in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 23-24 (1983), a case may "arise under" federal law by reason of Congress' replacement of a state law remedy with an exclusive federal remedy. The Court stated that "if a federal cause of action completely pre-empts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law."

Thus, in determining whether a complaint pleaded under state law may be removed as one "arising under"

federal law, the relevant inquiry for the district court is whether Congress has granted a federal remedy that preempts otherwise available state law remedies. See *Cahall v. Westinghouse Electric Corp.*, 644 F. Supp. 806, 808-811 (E.D. Pa. 1986) (sustaining removal of a state law complaint seeking ERISA benefits based on the preemption principles set forth in *Franchise Tax Board*).<sup>2</sup>

### III. Congress Has Preempted All Of Respondent's State Law Claims For Benefits By Enacting Section 502 (a)(1)(B) Of ERISA.

In addressing the issue of preemption in this case, respondent devotes most of his attention (Br. 27-45) to Section 514(a) of ERISA, 29 U.S.C. 1144(a), a provision that expressly preempts state law relating to employee benefit plans and prescribes a limited insurance saving clause. Respondent virtually ignores, however, Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), a provision that prescribes a federal cause of action that Congress intended to be preclusive of state remedies. This provision, standing by itself, suffices to preempt state law and provides a predicate for removal.<sup>3</sup>

<sup>2</sup> Respondent mischaracterizes (Br. 24) petitioners' position on federal preemption. Petitioners' position, clearly explained on page 26 of their opening brief, is that removal is proper under the "federal question" provision of the removal statute when the plaintiff's state law claim is preempted and when the plaintiff has a remedy under federal law.

<sup>3</sup> As discussed on pp. 10-14, *infra*, removal in this case also can be predicated on Section 514(a) of ERISA, as well as upon Congress' express grant of original jurisdiction to the district courts to adjudicate cases such as this one. Each ground is independently sufficient to support removal. The Solicitor General, joined by the Department of Labor, the agency charged with responsibility for administering ERISA, has filed an *amicus curiae* brief in *Pilot Life Ins. Co. v. Dedeaux*, No. 85-1043, urging that common law claims for benefits under ERISA-covered plans are preempted by both Sections 502(a)(1)(B) and 514(a) of ERISA. That brief demonstrates that Congress did not intend to permit participants in insured benefit plans to pursue any state law causes of action for denial of benefits available under ERISA plans.

A. Respondent's state law claims clash with the machinery prescribed by Congress for administration of ERISA plans. In passing ERISA, Congress found that the "continued well-being and security of millions of employees and their dependents are directly affected by these plans." 29 U.S.C. 1001(a). Based on these findings, Congress declared its intent to protect participants and beneficiaries "by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies." 29 U.S.C. 1001(b) (emphasis supplied).

To achieve these aims, Section 503 of ERISA, 29 U.S.C. 1133, establishes a "claims procedure" for initial processing of ERISA benefit claims. That review procedure applies to *all* claims; it does not distinguish between insured and self-insured plans. See 29 C.F.R. 2560.503-1(c). As discussed in petitioners' opening brief, preservation of state law remedies would allow participants to circumvent the federal claims procedure by going directly to state court.

Congress also prescribed a carefully-calibrated judicial remedy in Section 502 of ERISA, 29 U.S.C. 1132. Section 502, like the "claims procedure" of Section 503, does not distinguish between insured and self-insured plans. Congress provided six specific kinds of relief ranging from recovery of benefits to declaratory judgments with attorneys' fees in appropriate cases. Congress viewed the "six carefully-integrated civil enforcement provisions found in § 502(a) of the statute" as creating an "interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a 'comprehensive and reticulated statute.'" For this reason, it "did not intend to authorize other remedies." *Massachusetts Mutual Life Insurance Co. v. Russell*, — U.S. —, 105 S. Ct. 3085, 3093 (1985) (emphasis in original).

As the Solicitor General pointed out in his *amicus curiae* brief in *Pilot Life Insurance Co. v. Dedeaux*, No. 85-1043, at 7-8, preservation of state law remedies would impair this statutory scheme:

The remedies available to plan beneficiaries under ERISA may not include an award of punitive damages. . . . By contrast, remedies available under state common law, arising out of either tort or contract, may include not only punitive damages, as in this case, but also damages for pain and suffering and other consequential damages. . . . These further and open-ended differences resulting from the availability of general common law remedies may make funding welfare benefit plans by purchasing insurance relatively expensive compared with self-insuring. We doubt that Congress intended to create this more substantial incentive to self-insure since employees' benefits may be better protected by insured plans.

Preservation of conflicting state law remedies aimed at ERISA-covered plans would, quite simply, strip the gears of the federal law provisions governing claims for benefits. State law frequently differs from federal law on fundamental issues such as the plaintiff's right to trial by jury, the plaintiff's right to a *de novo* review of initial claims decisions, and the plaintiff's duty to exhaust internal remedies before filing suit. See petitioners' opening brief at 37-42.

Thus, it is hardly surprising that Congress stated its intent that the enforcement provisions of ERISA would displace state law occupying the same field. In the words of Senator Williams, the chairman of the Senate committee from which ERISA emanated, "the substantive and *enforcement provisions* of the conference substitute are intended to *preempt the field for Federal regulations*, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans." 120 Cong. Rec. 29933 (1974) (emphasis supplied).

B. There is no question that respondent's claims for "reimplementation of all benefits" under an ERISA-covered plan fall squarely within Section 502(a)(1)(B) of ERISA, a provision that encompasses claims for both insured and uninsured benefits. As the Solicitor General explained in his *amicus curiae* brief in *Pilot Life* (*id.* at

18), this federal remedy supersedes state law remedies otherwise available to respondent:

In our view the court below also too quickly dismissed the argument that the state remedies at issue here should be held to be preempted because ERISA's own remedial scheme for recovery of benefits was intended to be exclusive. We believe there is substantial support in the language and legislative history of ERISA for preserving the exclusivity of ERISA's remedial provisions, even if state law may coexist with federal law in other areas covered by ERISA.

Referring to Congress' intent that "[a]ll such actions in Federal or State courts are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act" (H.R. Conf. Rep. No. 93-1280, 93d Cong., 2d Sess. 327 (1974)), the Solicitor General observed (*amicus curiae* brief at 19):

This language clearly suggests that Congress intended the remedies it provided in Section 502 to be exclusive. It would be quite peculiar for Congress to have failed to mention in those sections of the committee reports dealing with Section 502 that alternative enforcement procedures in the form of state common law causes of action existed for those many employees participating in insured plans if in fact Congress did not intend the remedies provided in Section 502 to be exclusive.

Attributing to Congress an unexpressed intent to carve out an enclave for state law remedies whenever an employee benefit plan is "insured" would reduce the enforcement mechanism prescribed in ERISA to a virtual nullity. As noted in the Solicitor General's *amicus* brief at 19 n. 15, 91% of health plans covering fewer than 100 employees, and 83% of health plans covering more than 100 employees, are insured and administered by an insurance company.

Where, as here, Congress has created a federal cause of action that encompasses the claims in question, and

where it has expressed a policy in favor of "ready access" to the federal courts while forbidding application of state law, this Court should not hesitate to sustain removal. As stated by the majority in *Merrell Dow*, the significance of such a federal cause of action "cannot be overstated." 106 S. Ct. at 3234. Moreover, the dissenting Justices in *Merrell Dow* stressed the same proposition: if a private cause of action exists under federal law, there is removal jurisdiction in federal court "even if the plaintiff did not seek the federal remedy." 106 S. Ct. at 3241 n. 4.

#### IV. Congress Has Preempted All Of Respondent's State Law Claims For Benefits By Enacting Section 514(a) Of ERISA.

The preemptive impact of ERISA in this case flows not only from Section 502(a)(1)(B), discussed immediately above, but also from Section 514(a), 29 U.S.C. 1144(a). Section 514(a) broadly provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

Respondent nonetheless contends (Br. 27-45) that his common law claims for benefits are "saved" from preemption by virtue of the so-called insurance saving clause, Section 514(b)(2)(A), which provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . ." As the Solicitor General has noted in his *amicus* brief (*id.* at 12-19), a "common sense" construction of the insurance saving clause does not save from preemption common law claims of general applicability as alleged by respondent. Such common law causes of action cannot be equated with state law "which regulates insurance." Such claims, moreover, are far removed from the area which ERISA and the McCarran-

Ferguson Act have reserved for exclusive supervision by the states.<sup>4</sup>

A. In *Metropolitan Life Insurance Co. v. Massachusetts*, — U.S. —, 105 S. Ct. 2380, 2390 (1985), this Court gave the insurance saving clause a "common sense" construction and held that it preserves state insurance statutes that require insurers to include certain mandated benefits in insurance policies offered to ERISA plans. As the Solicitor General has noted, that construction of the insurance saving clause provides no support for an extension of the clause to encompass state law claims for benefits having no bearing on the insurance business in particular. *Amicus curiae* brief at 13-15. State law causes of action of general applicability are not laws which "regulate insurance" simply because they are applied, in a particular instance, to an insurance company.<sup>5</sup>

The better-reasoned lower-court decisions have analyzed the insurance saving clause in the same manner as the Solicitor General. For example, in *Benvenuto v. Connecticut General Life Insurance Co.*, 643 F. Supp. 87, 93 (D.N.J. 1986), the court rejected the contention that the insurance saving clause saves general common law causes of action alleging "breach of contract."

[P]laintiff's state law causes of action are not saved from preemption under the 'savings clause' found in

<sup>4</sup> Section 514(a) and the insurance saving clause are discussed in greater detail in the opening and reply briefs filed by petitioner in *Pilot Life Insurance Co. v. Dedeaux*, No. 85-1043.

<sup>5</sup> The Solicitor General's construction of Section 514(a) is supported by a comparison of the word "regulate" in the insurance saving clause with the broader phrase "relate to" in the preemption clause. If Congress intended to preserve state laws affecting insurance as broadly as it intended to preempt state laws affecting employee benefit plans, it could easily have used the more inclusive phrase "relate to" in both instances. Its failure to do so confirms the breadth of the preemption clause and the relative narrowness and specificity of the insurance saving clause.

§ 1144(b)(2)(A), which exempts from preemption 'any law of any state which *regulates* insurance.' A plain meaning, common sense analysis of the word 'regulate' precludes the clause's application here. . . . Plaintiff's argument that the *Metropolitan* case did not limit state action exempted under the savings clause to laws which regulate the *content* of insurance contracts is a valid one. However, even those actions which do not purport to regulate content must bear directly on insurance. These state causes of action do not.

Accord, *Northeast Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 158 n. 8 (3d Cir. 1985), observing that general "judge-made rules" are "not the kind of state insurance regulations that the Congress intended to preserve."

The recent decision of the Fourth Circuit in *Salomon v. Transamerica Occidental Life Insurance Co.*, 801 F.2d 659, 660-661 (4th Cir. 1986), further supports the distinction drawn by the Solicitor General. In that case, the Court concluded that general common law claims for breach of contract, aimed at an insured ERISA plan, are preempted: "ERISA clearly preempts Salomon's common law claims of breach of contract." *Id.* at 660.<sup>6</sup> Accord, *Globe v. Metropolitan Life Ins. Co.*, No. 86-CV-72695 (E.D. Mich. Nov. 25, 1986), slip op. 3: "Clearly, the present case is distinguishable since *Metropolitan*

<sup>6</sup> In *Salomon*, the court differentiated such general common law claims—which are not subject to the insurance saving clause—from claims brought under the provisions of "the Virginia insurance law." *Id.* at 661. The plaintiff's claims under the state insurance statute, which were alleged to be preserved by the insurance saving clause, were rejected by the court on the ground that the state legislature had not intended to confer a private cause of action. *Id.* at 661. As explained by the Solicitor General (*amicus curiae* brief at 18), Congress' intent that "ERISA's own remedial scheme for recovery of benefits . . . be exclusive" precludes application of either state statutory or common law to ERISA's claims processing system.

dealt with a 'mandated benefit' under state law. Plaintiff's claim herein is not based upon a law directed at the insurance industry, nor does it 'regulate insurance.' Rather, plaintiff asserts merely a common law breach of contract claim."

In the present case, the Solicitor General's construction of the plain language of the insurance saving clause is supported not only by the better-reasoned lower-court decisions, but also by the Department of Labor, the expert agency charged by Congress with responsibility for administering and enforcing ERISA. Under settled principles of statutory construction, the views of the expert agency are entitled to great deference. See, e.g., *Morrison-Knudsen Construction Co. v. Director, Office of Workers' Compensation Programs, Department of Labor*, 461 U.S. 624, 635 (1983).

B. This Court's decision in *Metropolitan* provides a second ground for holding that the insurance saving clause does not protect respondent's common law claims from preemption under Section 514(a). *Metropolitan* noted that the concept of "business of insurance" in the McCarran-Ferguson Act, 15 U.S.C. 1001 *et seq.*, is "directly relevant" in delineating the scope of ERISA's insurance saving clause. 105 S. Ct. at 2392 n. 21. Three criteria are considered in deciding whether a practice is part of the "business of insurance" under the McCarran-Ferguson Act: "'First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.'" 105 S. Ct. at 2391, quoting *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982).

At most, respondent's common law claims seeking payment of disability benefits implicate the second criterion; they arguably rest in part on the "policy relationship" between the insurer and the insured. Those common law

claims do not, however, satisfy the first or third McCarran-Ferguson Act criterion. Respondent's claims for recovery of benefits do not concern the transfer or spreading of risk, and his claims are not limited to entities within the insurance industry. In *Pireno*, 458 U.S. at 130-134, this Court referred to both factors in concluding that the McCarran-Ferguson Act was inapplicable, and it emphasized that "one 'indispensable characteristic of insurance' is the 'spreading and underwriting of a policyholder's risk'" (*id.* at 127).

Accordingly, respondent's common law claims seeking benefits under the General Motors employee benefit plan do not fall within the scope of the "business of insurance" reserved for state regulation under the McCarran-Ferguson Act and the insurance saving clause of ERISA. See *Benvenuto v. Connecticut General Life Insurance Co.*, *supra*, 643 F. Supp. at 93 ("Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within the Act's reference to the 'business of insurance.' . . . Utilizing these criteria, it is clear that state law actions in breach of contract, fraud and negligent mishandling of a claim do not operate to regulate insurance"); see also the Solicitor General's *amicus curiae* brief at 16-18. Because respondent's common law claims are not saved from preemption by the insurance saving clause, they are exclusively federal in nature and sufficient to support removal from state court.<sup>7</sup>

<sup>7</sup> As the Solicitor General's *amicus curiae* brief notes (*id.* at 16 n. 13), any difficulties presented in parsing the insurance saving clause "would not be presented if the Court holds that Congress intended the procedures it established in Section 502 to be the exclusive procedures for enforcing claims for benefits." In other words, federal preemption may be found to stem from either ERISA's general preemption provision (Section 514) or from ERISA's provision granting an exclusive federal remedy (Section 502).

**V. Respondent's Claim For Uninsured Salary Continuation Benefits Constitutes An Independent Federal Claim That Supports Removal Of The Entire Complaint.**

Even if ERISA's insurance saving clause were thought to save from preemption respondent's state law claims for "insured" benefits—which it does not for the reasons discussed immediately above—the insurance saving clause could not save from preemption respondent's independent claim for *uninsured* salary continuation benefits. As explained in petitioners' opening brief at pp. 46-48, that independent claim is necessarily preempted by ERISA and replaced by a federal cause of action, which supports removal of the entire complaint.

A. Respondent nonetheless argues (Br. 45-48) that his claim for salary continuation benefits, set forth in Count II, ¶ 23 of his original complaint (J.A. 22-23; see also *id.* at 236-237), is not preempted by ERISA. Respondent maintains that the General Motors salary continuation program does not fall within the definition of an employee welfare benefit plan under Section 3(1) of ERISA, 29 U.S.C. 1002(1), as interpreted by the Department of Labor. Respondent's argument rests on a fundamental misconception of the Department of Labor's interpretation.

The General Motors benefit plan provides salary continuation benefits that are "payable solely by General Motors Corporation." J.A. 46. Those benefits supplement insured sickness and accident benefits. *Ibid.* Sickness and accident benefits equal 75% of monthly salary, while salary continuation benefits equal 25% of monthly salary, for a specified period. J.A. 112, 117. Thus, the uninsured salary continuation benefits provided by General Motors represent only a fraction (25%) of normal compensation.

Respondent argues (Br. 46) that these salary continuation benefits are merely a continuation of "normal compensation" and, as such, are exempt from the definition of "employee welfare benefit plan" set forth in 29

C.F.R. 2510.3-1(b)(2). However, when promulgating this regulation, the Department of Labor made clear that only programs providing "normal compensation" fall outside the statutory definition. Thus, salary continuation programs are fully subject to ERISA if they provide less than "normal compensation" during periods of sickness or disability. As the Department of Labor has explained (40 Fed. Reg. 34526-34527 (Aug. 15, 1975)):

The explicit language of section 3(1) of the Act and the history of the Act indicate a Congressional intent to cover disability plans and other medical plans under which benefits generally consist of a scheduled percentage of normal compensation. These plans, moreover, have traditionally been regarded as employee benefit plans, rather than a continuation of wages or salary. If § 2510.3-1(b)(3) were extended to include payments of other than normal compensation while an employee is physically or mentally unable to perform duties or is absent for other medical reasons, these disability plans would be excluded from the welfare plan definition in section 3(1) of the Act, and, therefore, from Title I coverage altogether. Since this result would eliminate true disability plans from coverage under Title I and thereby violate not only traditional notions of what constitutes an employee benefit plan, but also the Congressional intent underlying section 3(1), § 2510.3-1(b) does not exclude from coverage practices which provide for payment of other than normal compensation while an employee is physically or mentally unable to perform his or her duties or is absent for other medical reasons.

Under this standard, the General Motors salary continuation program plainly is encompassed by ERISA because, in the words of the Department of Labor, it offers employees a "percentage of normal compensation." See also the *amicus curiae* brief of the ERISA Industry Committee (*id.* at 8 n. 9).

B. In attempting to avoid the preemptive impact of ERISA, respondent further contends (Br. 47-48) that his claim for salary continuation benefits is somehow a

claim brought "exclusively" against Metropolitan Life Insurance Company, and not against General Motors. That contention finds no support in the record. Not only is the complaint directed against both General Motors and Metropolitan jointly and severally, but the opening paragraph of the complaint makes the entire pleading applicable to both defendants. J.A. 19. The prayer for relief at the end of each count of the complaint makes no distinction among defendants (J.A. 21, 23), and Count II of the complaint incorporates each and every allegation of Count I. Thus, the complaint does not support respondent's assertion that his salary continuation claims were directed "against Metropolitan exclusively." Indeed, paragraph 21 of Count II of the complaint specifically enumerates the sickness and accident disability benefits provided through Metropolitan, while paragraph 23 of Count II of the complaint enumerates the salary continuation benefits provided through the "General Motors personnel benefit summary." J.A. 22.

Beyond this, in a colloquy in open court in which Judge Joiner inquired about respondent's salary continuation claim, respondent conceded that he sought salary continuation benefits from General Motors. At the hearing before Judge Joiner held on April 28, 1981, at which the court refused to remand this case to state court, the court observed: "This is a lawsuit against General Motors and Metropolitan and your prayer says you want all the benefits and insurance coverage to which you're entitled. One of the benefits that you allege that you're entitled to is salary continuation. . . . If you want to stay out of Federal Court, maybe the next time you don't want to join General Motors. . . ." Respondent's counsel replied: "Let's say, your Honor, that we have requested of General Motors certain benefits." District Court transcript at 6-7.<sup>8</sup>

<sup>8</sup> For the convenience of the Court, copies of the transcript have been lodged with the Clerk.

In short, respondent seeks salary continuation benefits that fall squarely within the coverage of ERISA. Since respondent seeks those benefits from General Motors, his claims are unaffected by the insurance saving clause and are subject to preemption. As explained on pp. 46-48 of petitioners' opening brief, claims for such uninsured benefits are exclusively federal in nature and suffice to support removal of the entire complaint. *Clorox v. U.S. District Court*, 779 F.2d 517 (9th Cir. 1985).

**VI. This Case Is Removable From State Court Because It Falls Within The District Court's Original Jurisdiction.**

Although the preemptive impact of ERISA in cases such as this one is of critical importance to the administration of the statute and of substantial relevance in analyzing the issue of removability, petitioners have demonstrated (Br. 43-45) that removal would be proper in this case even if ERISA had *no* preemptive impact on respondent's claim for benefits. That is so because respondent's claims fall squarely within the coverage of Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), which creates an express cause of action subject to the jurisdiction of the district court. Respondent's suit is, in the terms of the statute, a "civil action . . . by a participant . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits."

In granting "ready access to the Federal courts" in ERISA cases (29 U.S.C. 1001(b)), Congress permitted *all* such actions to be filed in the district court "without respect to the amount in controversy or the citizenship of the parties" (29 U.S.C. 1132(f)). There is no requirement that the plaintiff recite that such claims arise under federal law, or that the complaint refer, directly or indirectly, to ERISA. Any complaint that seeks benefits under an ERISA-covered plan falls within the original jurisdiction of the district court without regard to the legal theory asserted, the amount at stake, or the

citizenship of the litigants. See 29 U.S.C. 1132(e)-(f). Accordingly, a complaint such as respondent's complaint, when filed in state court, is removable to federal court under the unambiguous terms of the removal statute, 28 U.S.C. 1441(a)—which permits removal of "*any* civil action brought in a State court of which the district courts of the United States have original jurisdiction" (emphasis supplied). See also *Merrell Dow Pharmaceuticals, Inc. v. Thompson*, *supra*, 106 S. Ct. at 3234, 3241 n. 4, quoted on page 2, *supra*.

Respondent's only response to this analysis of the plain language of ERISA and the federal removal statute is the rhetorical assertion (Br. 21 n. 16) that permitting removal would "eviscerate the well-pleaded complaint doctrine." Quite to the contrary, however, respondent's complaint, reviewed on its face, shows all of the requisites for federal court jurisdiction under ERISA. The very same pleading could have been filed in federal court, and the federal court would have had original jurisdiction to adjudicate the controversy.

In a variant of the foregoing argument, respondent asserts (Br. 41 n. 35) that his suit would "only be an ERISA benefit case if respondent's state law actions were preempted." There is, however, not the slightest statutory basis for that argument. Under Section 502 of ERISA, the district court's jurisdiction does not depend on the complaint asserting a federal law issue and it does not depend on the complaint citing any federal statute. All that is required is that the plaintiff claim "benefits due to him under the terms of his plan"—a claim that respondent clearly has made. Respondent does not question Congress' constitutional authority to confer original jurisdiction over such cases, and, for the reasons stated on pp. 43-45 of petitioners' opening brief, Congress clearly has authority to do so under Article III and the Commerce Clause of the Constitution.

In sum, because respondent's claim indisputably falls within the original jurisdiction of the district court, and

because that jurisdiction does not depend on the complaint asserting any issue of federal law, the instant case is removable to federal court regardless of the scope of preemption under ERISA.<sup>9</sup>

### VII. Conclusion

For the reason stated in petitioners' opening brief and in this reply brief, the decision of the court of appeals should be reversed.

Respectfully submitted.

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<sup>9</sup> See 1A *Moore's Federal Practice* ¶ 0.157[5] at p. 121 (1986 ed.): "the reference in § 1441 to the original jurisdiction of the district court is not limited to the original jurisdictional grants contained in § 1331 and 1332; the reference is as broad as the district courts' original jurisdiction." See also, *Avco, supra*, 390 U.S. at 561-562, approving removal based on a federal statute granting original jurisdiction to the district courts as part of a program to "regulat[e] commerce."

**AMICUS CURIAE**

**BRIEF**

MAY 2 1986

JOSEPH F. SPANIOL, JR.,  
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

GENERAL MOTORS CORPORATION,

*Petitioner,*

v.

ARTHUR TAYLOR,

*Respondent.*

METROPOLITAN LIFE INSURANCE COMPANY,

*Petitioner,*

v.

ARTHUR TAYLOR,

*Respondent.*

On Writ of Certiorari  
to the United States Court of Appeals  
for the Sixth Circuit

BRIEF *AMICUS CURIAE* OF  
THE ERISA INDUSTRY COMMITTEE  
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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1985

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**Nos. 85-686 and 85-688**

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GENERAL MOTORS CORPORATION,  
*Petitioner,*

v.

ARTHUR TAYLOR,  
*Respondent.*

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METROPOLITAN LIFE INSURANCE COMPANY,  
*Petitioner,*

v.

ARTHUR TAYLOR,  
*Respondent.*

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On Writ of Certiorari  
to the United States Court of Appeals  
for the Sixth Circuit

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**BRIEF AMICUS CURIAE OF  
THE ERISA INDUSTRY COMMITTEE  
IN SUPPORT OF PETITIONERS**

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The issue presented in this case is whether a plaintiff can avoid federal jurisdiction over an action to recover benefits under an employee benefit plan regulated by the Employee Retirement Income Security Act of 1974 ("ERISA")<sup>1</sup> by failing to mention applicable federal statutory provisions in a complaint filed in state court. The resolution of this issue is a matter

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<sup>1</sup> Pub. L. No. 93-406, 88 Stat. 829 (1974), 29 U.S.C. §§ 1001 *et seq.*

of great significance to employers who maintain employee benefit plans regulated by ERISA and to employees who rely on these plans.

The ERISA Industry Committee ("ERIC") files this brief *amicus curiae* in support of petitioners' position that a defendant is entitled to remove an action such as this from state to federal court. In accordance with Supreme Court Rule 36.2, ERIC has submitted this brief within the time allowed for the filing of petitioners' briefs, and it has filed with the Clerk of this Court written consents to its participation from all parties to the proceeding below.<sup>2</sup>

### THE INTEREST OF THE *AMICUS CURIAE*

ERIC is a nonprofit association of over one hundred corporations doing business in a wide variety of American industries. A list of ERIC's members is set forth in the appendix hereto.

ERIC's membership comprises a broad cross-section of firms that maintain pension and welfare plans for their employees. All of the members of ERIC do business in more than one state, and some members maintain pension and welfare plans that provide benefits to employees in all fifty states. Salary continuation and disability payments of the kind at issue in this case are among the benefits provided under many of these plans.

Millions of persons are covered by plans that provide salary continuation, disability, and other benefits. Most claims for benefits made under these plans are granted without controversy. Inevitably, however, some claims are disputed, and some disputed claims result in litigation. Although the litigated cases represent a minute percentage of the aggregate number of claims filed, most of ERIC's members are involved

<sup>2</sup> The two parties who were defendants in the action below petitioned separately for review in this Court. The order granting *certiorari* consolidated the petitions.

in benefit claim litigation each year. Some are involved in only a few suits each year. Others may face several dozen benefit claim suits in a single year.

Individual members of ERIC may be named as defendants in suits arising under the same benefit plan in a number of different states. Because many of these suits are filed in state courts, ERIC's members frequently confront the question whether such actions may be removed to a federal district court as actions arising under ERISA. ERIC's members accordingly have a substantial interest in the resolution of the issue before the Court in this case.

### SUMMARY OF ARGUMENT

This case was properly removed under the provisions of the Judicial Code that permit a defendant to remove from a state to a federal court any action that lies within the original jurisdiction of the federal court. ERISA preempts state-law claims for benefits under an employee welfare benefit plan and provides plan beneficiaries with a superseding federal cause of action. An employee who seeks to recover benefits and to clarify his right to future benefits under an ERISA-regulated plan must rely on federal law for the relief he seeks. Accordingly, respondent's claim for past and future salary continuation and disability benefits necessarily arises under federal law, regardless of the wording of his complaint. For this reason, respondent's claims fall within the original jurisdiction conferred on the federal courts by 28 U.S.C. § 1331 and the case was properly removed pursuant to 28 U.S.C. § 1441(b).

The Sixth Circuit failed to recognize that federal law must be the source of any claim for benefits that respondent advances. In concluding that respondent's claim for benefits properly relied on state law, the Sixth Circuit ignored Congress's decision that the legal governance of such plans should be exclusively a federal concern. Congress expressly provided that ERISA covers employee welfare benefit plans such as the plan maintained by petitioner General Motors, regardless of

whether the plan provides benefits "through the purchase of insurance or otherwise."<sup>3</sup> The Sixth Circuit's conclusion that an employee may avoid federal jurisdiction by filing suit in a state court and characterizing his claim as a breach of contract action founded on state law conflicts with Congress's clear expression of its intent to occupy the field of employee benefit regulation.

## ARGUMENT

### Introductory Statement

Prior to the enactment of ERISA, employee benefit plans were regulated by a patchwork of state statutes and state common-law rules.<sup>4</sup> An employer who sought to maintain a uniform employee benefit plan for a multi-state work force encountered severe administrative difficulty and expense in complying with rules that differed from state to state. Such an employer was often prevented from providing its employees with the best possible benefits at the most reasonable cost.<sup>5</sup>

In recognition of the hardships and inequities that employees and employers alike suffered under state regulation of employee benefit plans, Congress included in ERISA a broad provision preempting "any and all State laws insofar as

<sup>3</sup> ERISA § 3(1), 29 U.S.C. § 1002(1).

<sup>4</sup> See 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits); 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams); 120 Cong. Rec. 29197 (1974) (remarks of Rep. Dent); see also Report of the ERISA Oversight Task Force on Pension and Welfare Plans, H.R. Rep. No. 1785, 94th Cong., 2d Sess. 38, 47 (1977) (stating that, prior to the enactment of ERISA, "[a] number of states had undertaken to regulate employee benefit plans as such; others had already made, or appeared ready to declare, these plans subject to state control as insurers, trust companies, or investment companies").

<sup>5</sup> Cf. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107 (1983) (describing the "administrative impracticality" of a regulatory scheme under which "[a]n employer with employees in several States would find its plan subject to a different jurisdictional pattern of regulation in each State, depending on what benefits the State mandated under disability, workmen's compensation, and unemployment compensation laws").

they may now or hereafter relate to any employee benefit plan . . . ." <sup>6</sup> Congress also created a federal remedy in section 502(a) of ERISA for the benefit claims that previously could be pursued only in state court.<sup>7</sup> The legislative history of section 502(a) states that actions brought under this section "are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947."<sup>8</sup>

The preemption of state laws that relate to employee benefit plans and the creation of federal rights and remedies in their stead are essential to fundamental policies of ERISA. The statute provides national uniformity in the regulation of employee benefit plans and promotes the growth and soundness of these plans through exclusive federal regulation under a unitary legal regime.

Because, as section 514(a) of ERISA plainly states, all state causes of action that "relate to any employee benefit plan" are preempted, respondent's action to recover benefits from an employee benefit plan and to clarify his right to future benefits can be maintained only under section 502(a) of ERISA. Because actions for benefits under ERISA-regulated benefit plans thus arise under federal law, they come within the removal jurisdiction of the federal courts.

<sup>6</sup> Section 514(a) of ERISA, 29 U.S.C. § 1144(a); see Report of the ERISA Oversight Task Force on Pension and Welfare Plans, H.R. Rep. No. 1785, 94th Cong., 2d Sess. 38, 47 (1977) (stating that Congress adopted this broad preemption language because it recognized the difficulty of "attempting to extricate these plans from the framework of state insurance, trust, and securities regulation even though their activities might very well bring them within the sphere of conduct historically subject to such regulation").

<sup>7</sup> See section 502(a) of ERISA, 29 U.S.C. § 1132, which provides that "[a] civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . ." Section 502(e)(1) of ERISA, 29 U.S.C. § 1132(e)(1), states that federal and state courts shall have concurrent jurisdiction over these actions.

<sup>8</sup> H.R. Rep. No. 1280, 93d Cong., 2d Sess. 327, reprinted in 1974 U.S. Code Cong. & Ad. News 5107.

# **I. Removal Is Proper When Federal Law Governs a Claim Alleged in the Complaint.**

The federal removal statute, 28 U.S.C. § 1441, permits a defendant to remove to federal court "any civil action brought in a State court of which the district courts of the United States have original jurisdiction . . . ." Thus, a defendant has the right to remove an action "arising under the . . . laws of the United States" because such an action falls within the original jurisdiction of the district courts under 28 U.S.C. § 1331.

It makes no difference that the respondent's complaint did not specifically invoke ERISA as the basis for his claim, nor does it matter that respondent purports to rely on state law. The essential consideration is whether the facts alleged and the relief sought place the claim among those that Congress ordained to be the exclusive province of federal law. In *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), this Court declared that "a plaintiff may not defeat removal by omitting to plead necessary federal questions in a complaint . . . ." 463 U.S. at 22. Although it is clear that "a defendant may not remove a case to federal court unless the plaintiff's complaint establishes that the case 'arises under' federal law," *id.* at 10, this requirement is met where federal law has preempted the cause of action alleged in the plaintiff's complaint. As the Court has noted, "if a federal cause of action completely pre-empts a state cause of action any complaint that comes within the scope of the federal cause of action necessarily 'arises under' federal law." *Id.* at 24, citing *Avco Corp. v. Aero Lodge No. 735, International Association of Machinists*, 390 U.S. 557 (1968). Accordingly, when a defendant invokes the removal jurisdiction of a federal court on the ground that the plaintiff's cause of action has been preempted by federal law, the court must examine the allegations of the plaintiff's complaint in light of the scope of the pertinent preemption statute to determine whether the cause of action is actually a federal one.

The key question is whether a claim advanced in the complaint can find life only under federal law. If so, the case arises under federal law and may be removed. "[A]n action arises under federal law if in order for the plaintiff to secure the

relief sought he will be obliged to establish both the correctness and the applicability to his case of a proposition of federal law." *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. at 9, quoting P. Bator, P. Mishkin, D. Shapiro & H. Wechsler, *Hart and Wechsler's The Federal Courts and the Federal System* 889 (2d ed. 1973). If, on the other hand, federal law merely provides or preempts a defense to a cause of action conferred by state law, the action itself does not "arise under" federal law, and removal jurisdiction does not exist. *Id.* at 10.

# **II. Respondent's Action Was Properly Removed to Federal Court Because It Arises Under Federal Law.**

In any case in which federal preemption is asserted as a ground for removal, removal is proper "when federal law not only displaces state law but also confers a federal remedy." *Hunter v. United Van Lines*, 746 F.2d 635, 642 (9th Cir. 1984), *cert. denied*, 106 S. Ct. 180 (1985); *see also New York v. Local 1115 Joint Board, Nursing Home & Hospital Employees Division*, 412 F. Supp. 720 (E.D.N.Y. 1976). The relevant provisions of ERISA contain the two elements of preemption identified in *Hunter v. United Van Lines*. ERISA explicitly displaces state-law causes of action to recover plan benefits, and it also provides plan beneficiaries with a federal remedy. Section 514(a) "supersede[s] any and all State laws insofar as they . . . relate to any employee benefit plan," and section 502(a) provides a federal cause of action for claims brought under ERISA-regulated benefit plans.

The subject matter of respondent's complaint plainly comes within the scope of these federal provisions. Count II of his complaint seeks "certain benefits and insurance coverages" that petitioner General Motors allegedly "agreed to provide" to respondent as a condition of his employment. Respondent alleges that he was wrongfully denied "salary continuation and/or disability benefits" due him under General Motors' benefit plan. Such a benefit plan is a prime example of the kind

of employee benefit plan that the federal government regulates through ERISA.<sup>9</sup> Accordingly, the question whether respondent can recover the benefits he seeks is governed by federal law.

**A. ERISA Preempts Respondent's Causes of Action For the Recovery of Benefits Under the ERISA-Regulated General Motors Benefit Plan.**

The preemption provision at section 514(a) of ERISA, which one court has called "the most sweeping federal preemption statute ever enacted,"<sup>10</sup> eliminates any state-law claim for benefits from an ERISA-regulated plan. This total preemption of state law reflects Congress's judgment that "the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of State action in the field of private employee benefit programs." 120 Cong. Rec. 29942 (1974) (remarks of Sen. Javits).<sup>11</sup>

**1. Federal Courts Have Recognized the Breadth of ERISA's Preemption Language.**

Courts have recognized that "not only th[e] literal language [of section 514(a)], but also its purpose, must be given force and effect." *Stone & Webster Engineering Corp. v. Ilesley*, 690 F.2d 323, 329 (2d Cir. 1982), *aff'd sub nom. Arcudi v.*

<sup>9</sup> Although the Department of Labor's regulation at 29 C.F.R. § 2510.3-1(b)(2) states that an unfunded program providing salary continuation benefits is not, standing alone, an "employee welfare benefit plan" governed by ERISA, salary continuation benefits are covered by ERISA when they are included in an ERISA-regulated welfare plan such as the General Motors plan. See ERISA § 3(1)(A), 29 U.S.C. 1002(1)(A); 29 C.F.R. § 2510.3-1(a)(2).

<sup>10</sup> *California Hospital Association v. Henning*, 569 F. Supp. 1544, 1546 (C.D. Cal. 1983), *rev'd on other grounds*, 770 F.2d 856 (9th Cir. 1985).

<sup>11</sup> See also 120 Cong. Rec. 29197 (1974) (remark of Rep. Dent that "[w]ith the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation"); 120 Cong. Rec. 29933 (1974) (remark of Sen. Williams that the principle of federal preemption "is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law").

*Stone & Webster Engineering Corp.*, 463 U.S. 1220 (1983); see also *Champion International Corp. v. Brown*, 731 F.2d 1406, 1409 (9th Cir. 1984) (observing that Congress enacted section 514(a) "to save employers from conflicting and inconsistent state and local regulation of employee benefit plans"); *General Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir. 1980) (holding that "[i]t is central to the statutory scheme that ERISA not be subject to state and local laws which might frustrate its goals"). This Court has read the preemption provision of ERISA broadly to effectuate the congressional intent. See *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

In *Shaw v. Delta Air Lines*, the Court described the scope of the preemption mandated by section 514(a) of ERISA. The Court held, "The breadth of § 514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." 463 U.S. at 96-97 (footnotes omitted). The Court explained:

... Congress used the words "relate to" in § 514(a) in their broad sense. To interpret § 514(a) to pre-empt only state laws specifically designed to affect employee benefit plans would be to ignore the remainder of § 514.

463 U.S. at 98. The Court concluded that the preemptive scope of section 514(a) is "as broad as its language." *Id.*

**2. ERISA Preempts the Causes of Action on Which Respondent Purports to Rely.**

Respondent's action clearly "relates to" an ERISA-regulated employee benefit plan. Respondent seeks to recover benefits allegedly due under petitioner's Insurance Program for Salaried Employees (the "GM Program"). The GM Program is, as the Sixth Circuit acknowledged, an employee welfare benefit plan regulated by ERISA. See *Taylor v. General Motors Corp.*, 763 F.2d 216, 218 (6th Cir. 1985) (citing section 3(1) of ERISA, 29 U.S.C. § 1002(1)).

The essence of Count II of respondent's complaint is that he has been denied benefits that petitioner General Motors

agreed to provide in the event of his disability. Respondent alleged in his complaint a right to salary continuation payments, which General Motors pays directly to disabled employees in addition to such disability benefits as may be provided through an insurance company. In addition to providing salary continuation benefits payable directly by General Motors, the GM Program provides disabled employees with sickness and accident benefits under a group insurance policy that petitioner General Motors carries under a contract with petitioner Metropolitan Life Insurance Company ("Metropolitan"). Respondent named General Motors and Metropolitan "jointly and severally" as defendants. Respondent sought to recover "compensatory damages for money contractually owed [respondent], compensation for mental anguish caused by breach of this contract, as well as immediate reimplementation of all benefits and insurance coverages [respondent] is entitled to, together with interest thereon, costs and attorney fees."

Federal courts of appeals have repeatedly held that section 514(a) of ERISA preempts state-law causes of action to recover benefits or to dispute the handling of claims under ERISA-regulated employee benefit plans.<sup>12</sup> For example, in *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419 (4th Cir. 1985), the Fourth Circuit held that ERISA preempted an employee's state-law claims for breach of contract and

<sup>12</sup> See, e.g., *Clorox Co. v. United States District Court*, 779 F.2d 517 (9th Cir. 1985) (employee's state-law claim that employment benefits had been wrongfully withheld was preempted by ERISA; action was properly removed on this basis to federal court); *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140 (4th Cir. 1985), *petition for cert. filed sub nom. Slack v. Burlington Industries, Inc.*, 54 U.S.L.W. 3470 (U.S. Jan. 14, 1986) (No. 85-929) and *appeal docketed sub nom. Brooks v. Burlington Industries, Inc.*, 54 U.S.L.W. 3428 (U.S. Dec. 24, 1985) (No. 85-944) (employees' state-law breach of contract claim for severance pay benefits was preempted by ERISA); *Gilbert v. Burlington Industries, Inc.*, 765 F.2d 320 (2d Cir.), *appeals docketed sub nom. Roberts v. Burlington Industries, Inc.*, 54 U.S.L.W. 3237 (U.S. Oct. 8, 1985) (No. 85-441) and *Gilbert v. Burlington Industries, Inc.*, 54 U.S.L.W. 3237 (U.S. Oct. 8, 1985) (No. 85-460) (same); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 968 (1981) (employees' state-law claims of tortious interference with employee benefit plans were preempted by ERISA).

intentional infliction of emotional distress arising out of the alleged mishandling of a claim for disability benefits provided by her employer. The court observed:

In this case, none of the state laws under which [plaintiff] claims relief have any intrinsic connection with employee benefit plans. The question is therefore whether state law claims which relate to the administration of an ERISA-governed plan, but which arise under general state laws which themselves have no impact on employee benefit plans, are within the scope of ERISA preemption. Given the "unparalleled breadth" of the preemption clause . . . and the broad remedial policy of ERISA, we hold that state laws, insofar as they are invoked by beneficiaries claiming relief for injuries arising out of the administration of employee benefit plans, "relate to" such plans and . . . are preempted by ERISA.

780 F.2d at 421. Similarly, in *Roe v. General American Life Insurance Co.*, 712 F.2d 450 (10th Cir. 1983), the Tenth Circuit found that ERISA preempted an employee's state-law claim against an insurer for disability payments under an insured welfare benefit program maintained by his employer.

As these and many other <sup>13</sup> decisions demonstrate, ERISA completely preempts an employee's state-law cause of action

<sup>13</sup> See also *Kilmer v. Central Counties Bank*, 623 F. Supp. 994 (W.D. Pa. 1985) (employee's state-law claim for health-care benefits was preempted by ERISA; action was properly removed on this basis to federal court); *Lucash v. Strick Corp.*, 602 F. Supp. 430 (E.D. Pa. 1984), *aff'd mem.*, 760 F.2d 259 (3d Cir. 1985) (employee's state-law cause of action to recover disability benefits was preempted by ERISA); *Nolan v. Aetna Life Insurance Co.*, 588 F. Supp. 1375 (E.D. Mich. 1984) (ERISA preempts state law claim for wrongful termination of disability benefits under an employee welfare benefit plan); *Ovitz v. Jefferies & Co.*, 574 F. Supp. 488 (N.D. Ill. 1983) (employee's state-law cause of action for breach of pension agreement was preempted by ERISA); *Shaw v. International Association of Machinists & Aerospace Workers Pension Plan*, 563 F. Supp. 653 (C.D. Cal. 1983), *aff'd*, 750 F.2d 1458 (9th Cir.), *cert. denied*, 105 S. Ct. 2678 (1985) (employee's state-law cause of action for breach of pension agreement was preempted by ERISA); *Leonardis v. Local 282 Pension Trust Fund*, 391 F. Supp. 554 (E.D.N.Y. 1975) (employee's state-law cause of action for pension benefits was preempted by ERISA; action was properly removed on this basis to federal court).

based on an ERISA-regulated employee benefit plan.<sup>14</sup> Accordingly, respondent may sue for breach of contract, infliction of emotional distress, and wrongful denial of benefits only under federal law.

**B. ERISA Creates a Superseding Federal Cause of Action That Governs Respondent's Claim For Benefits.**

Section 502(a) of ERISA, 29 U.S.C. § 1132(a), states that a participant in or beneficiary of an ERISA-regulated plan may bring a civil action "to recover benefits due to him under the terms of the plan, to enforce his rights under the terms of the plan, or to clarify his right to future benefits under the plan." Respondent seeks both to recover benefits provided under the GM Program and to clarify his right to future benefits under the program. Section 502(a) of ERISA thus provides respondent with a federal cause of action in place of the state law claims that section 514 preempts. His cause of action accordingly "arises under" section 502(a) and was properly removed to federal court under 28 U.S.C. § 1441(b).

This conclusion is illustrated by *Clorox Co. v. United States District Court*, 779 F.2d 517 (9th Cir. 1985). There the court held that plaintiff's state-law claim for wrongful termination of plan benefits was preempted, and that the case was properly removed because "ERISA creates a federal cause of action, with concurrent state and federal jurisdiction, over claims by an employee 'to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.'" 779 F.2d at 521.<sup>15</sup>

<sup>14</sup> State courts in Michigan, where respondent's complaint was filed, have recognized the preemptive force of ERISA. See *Martin v. Metropolitan Life Insurance Co.*, 140 Mich. App. 441, 364 N.W.2d 348 (1985); *Rhodes v. Aetna Life Insurance Co.*, 135 Mich. App. 735, 356 N.W.2d 247 (1984).

<sup>15</sup> See also *Kilmer v. Central Counties Bank*, 623 F. Supp. 994 (W.D. Pa. 1985) (removal of claim for health care benefits was proper because ERISA preempted state-law causes of action and provided a federal remedy in their stead); *Nolan v. Aetna Life Insurance Co.*, 588 F. Supp. 1375 (E.D. Mich.

(footnote continues)

The broad preemption provision at section 514(a) of ERISA, and the specific cause of action created in section 502(a) of ERISA, convert respondent's purported state claims into federal claims. Because respondent's claims could be maintained only under federal law, his action was properly removed to federal court.

**III. The Sixth Circuit Erred in Holding That Respondent's Action Was Improperly Removed From State Court.**

The Sixth Circuit's analysis is replete with errors. Perhaps that court's most striking error is its conclusion that it had no need to determine whether ERISA preempts any of the claims respondent prosecutes in this case.

The Sixth Circuit observed that federal courts have reached conflicting decisions on the question whether a claim such as the respondent's necessarily arises under federal law. *Taylor v. General Motors Corp.*, 763 F.2d at 219. Because of the confusion created by this conflict of decisions, the court concluded that it was not "clearly established" that respondent's complaint stated a federal claim. The court found that removal was improper for this reason, and it refused to reach its own resolution of the central preemption question in the case. Instead, it stated, "We express no opinion concerning whether Congress intended ERISA to preempt the type of claim brought by plaintiff in this case." *Id.* at 220.

It is clear that the Sixth Circuit could not determine whether respondent's action was properly removed without reaching the question whether Congress intended ERISA to preempt his claim. There is no basis for the Sixth Circuit's statement that the question whether respondent's claim is preempted and the question whether removal jurisdiction exists

(footnote continued)

1984) (removal of action to recover disability benefits was proper because ERISA preempted state-law claims for breach of contract and infliction of emotional distress and provided a federal remedy under section 502(a)); *Leonardis v. Local 282 Pension Trust Fund*, 391 F. Supp. 554 (E.D.N.Y. 1975) (plaintiff's state breach of contract action for pension benefits was properly removed because it in reality stated a claim under section 502(a) of ERISA).

"are separate and distinct." *Id.* at 220 n.1. The decisions of this Court have established that where federal law preempts a state cause of action and substitutes a federal one, the case arises under federal law, so that federal jurisdiction exists and removal is proper. *See Federated Department Stores, Inc. v. Moitie*, 452 U.S. 394 (1981).

The Sixth Circuit's citation of several employee benefit cases involving claims against insurance companies suggests the view that respondent might be able to invoke the "insurance saving clause" in section 514(b) of ERISA to preserve his claim against Metropolitan from preemption. This so-called saving clause states that the preemption provisions of ERISA shall not be construed "to exempt or relieve any person from any law of any State which regulates insurance . . . ." However, respondent could not avoid removal even if section 514(b) did apply to his claim against Metropolitan. His claim for uninsured salary continuation benefits can be maintained only against General Motors and not against Metropolitan. Even if section 514(b) did save respondent's claim against Metropolitan from preemption, his claim against General Motors would nonetheless be governed by federal rather than state law, making removal of the case proper. *See* 28 U.S.C. § 1441(c).

Even if respondent had not brought a claim against General Motors for uninsured salary continuation benefits, and had named only Metropolitan in his claim for disability benefits, the saving clause would not apply to this case. A few courts have held that a claim for benefits under an ERISA-regulated plan is preserved from preemption by the saving clause if the claim is brought solely against an insurer.<sup>16</sup> However, state common-law claims for breach of contract, such as the claims asserted in respondent's complaint, are not laws that "regulate insurance" within the meaning of ERISA's saving clause, but rather are laws of general applicability that relate only incidentally to insurance contracts.

<sup>16</sup> *See, e.g., Dedeaux v. Pilot Life Insurance Co.*, 770 F.2d 1311 (5th Cir. 1985), *petition for cert. filed*, 54 U.S.L.W. 3437 (U.S. Dec. 16, 1985) (No. 85-1043); *Eversole v. Metropolitan Life Insurance Co.*, 500 F. Supp. 1162 (C.D. Cal. 1980). On February 24, 1986, the Court requested that the Solicitor General express the views of the United States on the issues raised in the *Pilot Life* case.

When the Court interpreted section 514(b) in *Metropolitan Life Insurance Co. v. Massachusetts*, 105 S. Ct. 2380 (1985), it looked for guidance to the case law interpreting the provision of the McCarran-Ferguson Act that preserves the right of the states to regulate the "business of insurance." 105 S. Ct. at 2391. The Court observed that "[t]he ERISA saving clause, with its similarly worded protection of 'any law of any State which regulates insurance,' appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Id.* at 2392 n.21. The cases applying the McCarran-Ferguson Act firmly establish that the statute's reference to state laws regulating the "business of insurance" does *not* include "laws of general applicability pertaining to the method of handling contract disputes."<sup>17</sup> Instead, the McCarran-Ferguson Act, like section 514(b) of ERISA, preserves from federal preemption only those state laws that speak solely to the relationship between an insurance company and its insured.

The Sixth Circuit also erroneously concluded that removal was improper because respondent had characterized his claim as one "based solely on state contract law . . . ." 763 F.2d at 218. In reaching this conclusion, the Sixth Circuit misconstrued this Court's holding in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983). In the latter case, a California agency filed suit in state court to enforce state tax levies against funds that were held in an ERISA-regulated trust for the benefit of several delinquent taxpayers. This Court found that the lower federal courts had improperly invoked ERISA as a basis for removal of the action. The Court noted that the defendants could look to ERISA for a preemptive defense to the state tax levy, but it held that ERISA did not preempt the agency's cause of action because ERISA "neither creates nor expressly denies any cause of action in favor of state

<sup>17</sup> *Hart v. Orion Insurance Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971) (holding that the state arbitration statutes cited by a plaintiff who sought to recover disability benefits from the defendant insurer were not within the scope of the McCarran-Ferguson Act's insurance saving clause); *see also Hamilton Life Insurance Co. v. Republic National Life Insurance Co.*, 408 F.2d 606, 611 (2d Cir. 1969); *Securities & Exchange Commission v. Republic National Life Insurance Co.*, 378 F. Supp. 430, 436 (S.D.N.Y. 1974).

governments, to enforce tax levies or for any other purpose." 463 U.S. at 25. The Court stated that "a case may not be removed to federal court on the basis of a federal defense, including the defense of preemption . . ." *Id.* at 14. The Court recognized, however, that a case may be removed from state court if "federal law creates the cause of action" on which the plaintiff relies. *Id.* at 27-28. The Sixth Circuit failed to understand that section 502(a) of ERISA creates respondent's cause of action, and that this case accordingly was properly removed under the Court's analysis in *Franchise Tax Board*.

The Court noted in *Franchise Tax Board* that removal was in cases in which the facts alleged in a complaint stated a cause of action under such comprehensive federal statutes as § 301 of the Labor-Management Relations Act, whose preemptive force "is so powerful as to displace entirely any state cause of action 'for violation of contracts between an employer and a labor organization.'" *Id.* at 23. The Court observed:

ERISA contains provisions creating a series of express causes of action in favor of participants, beneficiaries, and fiduciaries of ERISA-covered plans . . . [citing section 502(a)]. It may be that, as with § 301 as interpreted in *Avco*, any state action coming within the scope of § 502(a) of ERISA would be removable to federal district court, even if an otherwise adequate state cause of action were pleaded without reference to federal law.

*Id.* at 24.

The legislative history of section 502(a) of ERISA states that actions under section 502(a) "are to be regarded as arising under the laws of the United States in similar fashion to those brought under Section 301 of the Labor-Management Relations Act of 1947." H.R. Rep. No. 1280, 93d Cong., 2d Sess. 327, reprinted in 1974 U.S. Code Cong. & Ad. News 5107. Accordingly, the Sixth Circuit erred in holding that "cases implicating

ERISA . . . differ from those involving the federal labor laws generally." 763 F.2d at 220.<sup>18</sup>

The Sixth Circuit failed to distinguish between a case in which a federal statute precludes the enforcement of a plaintiff's state-law claim and a case in which a federal statute replaces plaintiff's state-law cause of action with a federal one. See *Taylor v. General Motors Corp.*, 716 F.2d at 219. The Sixth Circuit erroneously concluded that the ERISA provisions constitute a federal defense rather than the source of plaintiff's claim because the matter of preemption was first raised in the defendants' removal petition rather than in the plaintiff's complaint. In reaching this conclusion, the Sixth Circuit failed to recognize that if "a state right of action has been replaced by a federal right of action, plaintiff necessarily is stating a federal claim whether he wishes to do so or not, and the case is removable." C. Wright, *The Law of Federal Courts* 216 (4th ed. 1983).

The Sixth Circuit acknowledged that "the plan at issue is regulated by ERISA, and [that] ERISA preempts all state laws in this field . . ." 763 F.2d at 218. The court failed, however,

<sup>18</sup> Section 502(e) of ERISA provides for concurrent jurisdiction in state and federal court over actions brought pursuant to section 502(a). The concurrent jurisdiction provision in section 502(e) does not, however, give respondent the right to keep his action in state court. In *McConnell v. Marine Engineers Beneficial Association*, 526 F. Supp. 770 (N.D. Cal. 1981), the court held:

The grant of concurrent jurisdiction in ERISA over certain actions clearly gives the plaintiff the initial choice of forum. However, this choice is not absolute but rather is subject to the defendant's right to remove. By enacting the removal statute, Congress has granted defendants a right to have any action coming under the original jurisdiction of the district courts tried in those courts unless the legislature makes an express determination that such removal is unwarranted. Such a determination was not made in this case.

526 F. Supp. at 773; see also *Buck v. Union Trustees of the Plumbers and Pipefitters National Pension Fund*, 70 F.R.D. 530, 531 (E.D. Tenn. 1975) ("While the plaintiff had a right to choose initially the state court as the forum of his action [under § 502(a)], the defendants had a subsequent equal right to resort to an appropriate federal court by compliance with the removal statute . . .").

to draw the necessary conclusion that respondent's claim for benefits under the plan arose under federal law. ERISA expressly and exclusively governs all claims such as the purported state causes of action that respondent pleaded in his complaint. For these reasons, respondent's benefit claim is subject to the same analysis that this Court applied to section 301 of the Labor-Management Relations Act in *Avco*: his claim "is purely a creature of federal law, notwithstanding the fact that state law would provide a cause of action in the absence of [the federal statute]." *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. at 23 (describing the *Avco* holding). Thus, the action was properly removed to federal court.

### CONCLUSION

This case was properly removed to the United States District Court because Congress intended issues affecting employee benefit plans regulated by ERISA to be governed by federal law. Thus, Congress included in ERISA a broadly-worded clause preempting all state laws insofar as they "relate to any employee benefit plan." ERISA § 514(a), 29 U.S.C. § 1144(a). Congress sought to have uniform federal law rather than diverse state laws govern claims made under employee benefit plans. The action therefore is one "arising under" the laws of the United States, 28 U.S.C. § 1331, and accordingly was properly removed to the federal courts under 28 U.S.C. § 1441.

It is of paramount importance that the statutory preemption provisions of ERISA be honored. Employers cannot fairly and effectively negotiate and administer employee benefit plans with multi-state coverage unless questions concerning the rights of plan beneficiaries are resolved by the application of uniform principles of federal law, as Congress intended and required. These principles are most effectively developed and consistently applied by the federal courts, which are familiar with ERISA and with the precepts of federal tax and labor law that often illuminate the resolution of ERISA cases. If plaintiffs are permitted to defeat federal jurisdiction by filing their complaints in state court and arguing that they rest their claims

solely on preempted provisions of state law, then defendants in benefit claim suits will be denied the access to a federal forum with which Congress provided them.

The decision of the court below should be reversed.

Respectfully submitted,

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May 2, 1986

**APPENDIX**

**THE ERISA INDUSTRY COMMITTEE  
MEMBERSHIP LIST  
May, 1986**

Aetna Life & Casualty Company  
Alexander & Alexander Services, Inc.  
Allied Corporation  
Aluminum Company of America  
AMAX Inc.  
American Telephone & Telegraph Company  
Amoco Corporation  
Apache Corporation  
Atlantic Richfield Company  
Baltimore Gas and Electric Company  
Bank of America N.T. & S.A.  
Bankers Trust Company  
Bell Communications Research  
Bell South Corporation  
Bethlehem Steel Corporation  
The Boeing Company  
Bristol-Myers Company  
Buck Consultants, Inc.  
The Chase Manhattan Bank, N.A.  
Chesebrough-Pond's, Inc.  
Chevron Corporation  
Ciba-Geigy Corp.  
Citibank, N.A.  
The Coca-Cola Company  
Columbia Gas System Service Corp.  
Combustion Engineering, Inc.  
Connecticut General Life Insurance Co.  
The Continental Group, Inc.  
Coopers & Lybrand  
Dana Corporation  
Dart & Kraft Inc.  
Deere & Company  
Delta Air Lines Inc.  
Digital Equipment Corp.

R. R. Donnelley & Sons Company  
 The Dow Chemical Company  
 Dresser Industries, Inc.  
 E.I. du Pont de Nemours & Company, Incorporated  
 Eastman Kodak Company  
 Eli Lilly and Company  
 Equitable Life Assurance Society of the United States  
 Exxon Corporation  
 Federated Department Stores, Inc.  
 FMC Corporation  
 Ford Motor Company  
 General Electric Company  
 General Motors Corporation  
 W. R. Grace & Co.  
 The Greyhound Corporation  
 Grumman Corporation  
 GTE Corporation  
 Gulf & Western Industries, Inc.  
 Frank B. Hall Consulting Company  
 John Hancock Mutual Life Insurance Co.  
 A.S. Hansen, Inc.  
 Hazlehurst & Associates, Inc.  
 H.J. Heinz Company  
 Hewitt Associates  
 ICI Americas, Inc.  
 International Business Machines Corporation  
 International Harvester Company  
 International Paper Company  
 International Telephone & Telegraph Corporation  
 Internorth, Inc.  
 Johnson & Higgins, Inc.  
 Johnson & Johnson  
 Knight-Ridder Newspapers, Inc.  
 The LTV Corporation  
 Manufacturers Hanover Trust Company  
 William M. Mercer, Inc.  
 Metropolitan Life Insurance Company  
 Minnesota Mining & Manufacturing Co.  
 Mobil Oil Corporation

Mutual Life Insurance Company of New York  
 Nabisco Brands, Inc.  
 NYNEX Corporation  
 Occidental Petroleum Services, Inc.  
 Olin Corporation  
 Owens-Illinois, Inc.  
 Pacific Gas & Electric Company  
 J. C. Penney Co., Inc.  
 Pennzoil Company  
 PPG Industries, Inc.  
 Procter & Gamble Company  
 The Prudential Insurance Company of America  
 Ralston Purina Company  
 RCA Corporation  
 R.J. Reynolds Industries, Inc.  
 Rockwell International Corporation  
 Sara Lee Corporation  
 Sears, Roebuck and Company  
 Shell Oil Company  
 The Southland Corporation  
 Sperry Corporation  
 Standard Oil Company of Ohio  
 Sun Company, Inc.  
 Tenneco Inc.  
 Texaco Inc.  
 Textron Inc.  
 Time Incorporated  
 Towers, Perrin, Forster & Crosby Inc.  
 The Travelers Insurance Company  
 TRW Inc.  
 Union Camp Corporation  
 Union Carbide Corporation  
 United States Steel Corporation  
 United Technologies Corporation  
 U S WEST, Inc.  
 Westinghouse Electric Corporation  
 The Wyatt Company  
 Xerox Corporation

# **CERTIFICATE OF SERVICE**

I certify that on this 2nd day of May, 1986, I served the foregoing brief on each of the parties by sending three copies thereof by first class mail, postage prepaid, to:

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